NEW YORK HEAD & NECK INSTITUTE
LENOX HILL/MEETH – NS/LIJ HEALTH SYSTEM

PATIENT INFORMATION

Patient Name: ______________________ Soc. Sec. #: ____________

Address: ______________________ Apt ______ City: ____________

State: ________ Zip: ____________ Date of Birth: ____________ Age: ____

Home Phone: ( ) ____________ Work Phone: ( ) ____________

Cell Phone: ( ) ____________ E-Mail Address ____________

Sex: M F Marital Status: S M D W

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: ____________ Relationship: ____________ Phone: ( ) ____________

EMPLOYER
Name: ______________________
Address: ______________________

PRIMARY CARE PHYSICIAN or REFERRING PHYSICIAN (to whom reports may be sent)
Name: ____________ Phone: ( ) ____________
Address: ______________________

WHO REFERRED YOU TO THIS OFFICE?
Referring Physician Name: ____________ □ Friend (Name): ____________
□ Health Insurance Company □ Website □ Other ____________

INSURANCE INFORMATION

	#1	#2
Insurance Company		
Address		
City, State, Zip		
Phone #		
Policyholder Name		
Insured's Birthdate, SS#		
Relationship to Patient		
Policy #, Group #		
Co-Pay Amount		

I have received a copy of the NYHNI's Notice of Privacy Practices. I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. In accordance with medical treatment, there may be procedures or tests performed at additional cost. I authorize direct payment of covered benefits to the provider of professional services. The patient is responsible for all fees, regardless of insurance coverage. Payment for office visits is expected at the time of service. Credit cards or Debit Cards may be used, in addition to cash or check.

Date: ____________ Patient Signature: ______________________

North Shore-LIJ Health System

PATIENT HEALTH QUESTIONNAIRE (Please Print)

PATIENT INFORMATION

Name ______________________________ **Date** ________________

Height __________ Weight ____________ lbs. Gender ☐ Male ☐ Female

CHIEF COMPLAINT / HISTORY OF ILLNESS

What is the reason for today's consultation? ______________________________

How long have you had this problem? ______________________________

How severe is this problem? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Mild Very Severe

How often does this problem occur? ☐ constant ☐ comes and goes

What makes it better? ______________________________

What makes it worse? ______________________________

What other symptoms are you having? ______________________________

PAST MEDICAL HISTORY (Please check any illnesses you have)

☐ High blood pressure	☐ Asthma/Emphysema	☐ Rheumatic fever	☐ Others
☐ Kidney Disease	☐ Stroke/ Mini-stroke	☐ Sinusitis	____________
☐ Diabetes	☐ Heart disease/Angina`	☐ Peptic ulcers	____________
☐ Neck/back disease	☐ Hepatitis/Liver disease	☐ Thyroid disease	____________
☐ Poor circulation	☐ Seizures	☐ Bleeding problems	____________

☐ Cancer treatment (Please list type and date) ______________________________

PAST SURGICAL HISTORY (Please check any surgeries you have had)

☐ Heart bypass/valve	☐ Gall bladder	☐ Prostate removal	☐ Others
☐ Coronary angioplasty	☐ Lung surgery	☐ Colon removal	____________
☐ Carotid artery surgery	☐ Joint replacement	☐ Appendix removal	____________
☐ Vascular bypass	☐ Back surgery	☐ Sinus Surgery	____________
☐ Mastectomy	☐ Brain surgery	☐ Tonsillectomy	____________
☐ Heart transplant	☐ Liver transplant	☐ Kidney Transplant	____________
☐ Ear surgery	☐ Septoplasty	☐ Neck surgery	____________

☐ Cancer surgery (Please list type and date) ____________________

MEDICATIONS (Please list all your current medications and the dose you take)

Current Medications	Dosage/Frequency	Current Medications	Dosage/Frequency

Do you take Aspirin or Ibuprofen ☐ Yes ☐ No
Do you take any herbal medicines? ☐ Yes ☐ No
Do you take Warfarin (Coumadin) ☐ Yes ☐ No
Have you taken steroids in the last year? ☐ Yes ☐ No

ALLERGIES (Please list medications/foods you are allergic to and what happens when you take them)

Allergen	Reaction	Allergen	Reaction

FAMILY HISTORY (Please check all illnesses that run in your family)

☐ Hearing loss
☐ High blood pressure
☐ Sickle Cell Anemia
☐ Poor circulation
☐ Thyroid disease/cancer
☐ Alcoholism
☐ Psychiatric illness
☐ Bleeding problems
☐ Anesthesia reaction
☐ Voice problems
☐ Heart disease
☐ Cancer
☐ Diabetes
☐ Stroke
☐ Epilepsy
☐ Others ____________________

SOCIAL HISTORY

Occupation____________________ How many children do you have ____________________

Marital status ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Living with partner ☐ Widowed

Check tobacco products you use your have used in the past ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ Never used

How much, and for how long have you used tobacco? __________ per day ______ years ☐ Never used

How much alcohol do you drink each day? ________________ How much caffeine do you drink per day? __________

REVIEW OF SYSTEMS (Please check all symptoms you have had either now or in the past)

CONSTITUTIONAL:

☐ Weight loss ______ pounds in the past ______ weeks ☐ Fever, chills ☐ Weakness or fatigue

EYES:

☐ Double vision
☐ Loss of vision

EARS, NOSE, THROAT:

☐ Hearing loss
☐ Ringing in ears
☐ Nose bleeds
☐ Nose drainage
☐ Swallowing pain
☐ Voice change

☐ Eye pain ☐ Dizziness ☐ Nasal congestion ☐ Snoring

☐ Eye drainage ☐ Ear pain ☐ Facial pain ☐ Hoarseness

☐ Dry eyes ☐ Ear drainage ☐ Headaches ☐ Poor sleep

☐ Toothaches ☐ Sore mouth/throat ☐ Neck pain or swelling

CARDIOVASCULAR/PULMONARY:

☐ Chest pain ☐ Heart attack ☐ Irregular heartbeat ☐ Bronchitis

☐ Poor circulation ☐ Leg pain during walking ☐ Frequent cough ☐ Coughing up blood

☐ Shortness of breath ☐ Asthma or wheezing

GASTROINTESTINAL:

☐ Stomach ulcers ☐ Nausea/vomiting ☐ Diarrhea ☐ Frequent antacid use

☐ Heartburn ☐ Trouble swallowing ☐ Abdominal pain ☐ Blood in stool

GENITOURINARY:

☐ Blood in urine ☐ Pain during urination ☐ Difficulty making urine

MUSCULOSKELETAL:

☐ Neck or back pain ☐ Muscle aches ☐ Arthritis

NEUROLOGICAL:

☐ Stroke ☐ Min-stroke or TIA ☐ Head trauma ☐ Seizure

☐ Facial paralysis ☐ Paralysis of arm or leg ☐ Confusion ☐ Memory loss

☐ Numbness in face, arms or legs ☐ Temporary loss of vision or speech control

SKIN:

☐ Skin cancers ☐ Allergy to tape, iodine or latex

PSYCHIATRIC:

☐ Depression ☐ Schizophrenia ☐ Other psychiatric disorders (Please list)

☐ Hallucinations ☐ Anxiety or panic attacks ______________________________

INFECTIOUS DISEASE:

☐ Hepatitis ☐ HIV/AIDS ☐ Mononucleosis ☐ Shingles

☐ Syphilis ☐ TB ☐ Any sexually transmitted disease ______________________________

____

Patient Signature **Date**

Physician Statement: I have personally reviewed this history and review of systems.

____

Attending Physician's Signature **Date**

The North Shore-LIJ Health System

FINANCIAL RESPOSIBILITY EXPLANATION

Welcome to our office and thank you for trusting us with your medical care. We strive to provide the best possible treatment and outcomes for our patients.

We are well aware that the treatment process is as much emotional as it is physical, and can cause a strain on the entire family. Our office staff is here to assist you in any way possible. We are able to assist not only with financial matters but are here to provide emotional support as well.

Due to the unique nature of this practice, our physicians do not participate in many commercial & managed care insurance programs. Most medical care provided is "out of network". Your responsibility including annual deductible or coinsurance amounts is determined by the way your insurance policy is written. You are responsible for these amounts personally, as it will not be covered by your insurance carrier. As a courtesy to our patients since we know the process can be complicated, we will bill the insurance company directly. Our goal is to collect the fees from the insurance company so that you will not have to pay this amount out of pocket.

Once you receive from the insurance company your first Explanation of Benefits (EOB) for our practice, please contact your insurance company to verify appropriate payment explanation and help expedite the collection process. If your insurance company does not initially pay, we will make at least two attempts at fighting them in order to receive the professional fees. During this time, it is often helpful for you to contact the insurance company as well to help push for resolution. If after 90 days we are still not successful at recouping our fees from your insurance company you will receive a bill.

We will do our best to help guide you through the billing process and expect the same courtesy in return. If you receive a bill from our office you agree to contact our office within 10 days in order to arrange payment.

I have read and understand my financial responsibilities.

PRINT NAME ______________ SIGNATURE ______________ DATE ______