

**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

Center for Cranial Base Surgery · Center for Facial Reconstruction · Center for Head & Neck Oncology · Center for Sinus & Allergy · Center for Sleep Disorders · Center for Aesthetic Facial Plastic Surgery · Center for Thyroid & Parathyroid Surgery · Center for Voice & Swallowing Disorders

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 Warfarin (Coumadin) Yes No
Do you take any herbal medicines? 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)

- | | | | |
|---|--|--|---------------------------------|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Others |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Anesthesia reaction | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Thyroid disease/cancer | <input type="checkbox"/> Voice problems | <input type="checkbox"/> Epilepsy | _____ |

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 you 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:

EARS, NOSE, THROAT:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Swallowing pain |
| <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nose drainage | <input type="checkbox"/> Voice change |

- | | | | |
|---------------------------------------|---------------------------------------|--|--|
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Eye drainage | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Ear drainage | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor sleep |
| | <input type="checkbox"/> Toothaches | <input type="checkbox"/> Sore mouth/throat | <input type="checkbox"/> Neck pain or swelling |

CARDIOVASCULAR/PULMONARY:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Leg pain during walking | <input type="checkbox"/> Frequent cough | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma or wheezing | | |

GASTROINTESTINAL:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Frequent antacid use |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Blood in stool |

GENTOURINARY:

- | | | |
|---|--|--|
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Pain during urination | <input type="checkbox"/> Difficulty making urine |
|---|--|--|

MUSCULOSKELETAL:

- | | | |
|--|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Neck or back pain | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Arthritis |
|--|---------------------------------------|------------------------------------|

NEUROLOGICAL:

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Min-stroke or TIA | <input type="checkbox"/> Head trauma | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Facial paralysis | <input type="checkbox"/> Paralysis of arm or leg | <input type="checkbox"/> Confusion | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Numbness in face, arms or legs | | <input type="checkbox"/> Temporary loss of vision or speech control | |

SKIN:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Skin cancers | <input type="checkbox"/> Allergy to tape, iodine or latex |
|---------------------------------------|---|

PSYCHIATRIC:

- | | | |
|---|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Other psychiatric disorders (Please list) |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Anxiety or panic attacks | _____ |

INFECTIOUS DISEASE:

- | | | | |
|------------------------------------|-----------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> TB | <input type="checkbox"/> 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 RESPONSIBILITY 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