

**– Patient Information –**

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

E-mail address (optional) \_\_\_\_\_

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Family or referring physician \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

**– Primary Insurance –**

Plan Name \_\_\_\_\_ Number \_\_\_\_\_

Plan Address \_\_\_\_\_ Group Number \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Policy Holder' Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First

Policy Holder' Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Relationship to Patient (please check): ( ) self, ( ) spouse, ( ) parent, ( ) other

**– Additional Insurance –**

Plan Name \_\_\_\_\_ Number \_\_\_\_\_

Plan Address \_\_\_\_\_ Group Number \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Policy Holder' Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First

Policy Holder' Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Relationship to Patient (please check): ( ) self, ( ) spouse, ( ) parent, ( ) other

**– Person Responsible for Bill or Parent (for Minors)**

Complete only if different from patient

Guarantor's/ Parent's Name \_\_\_\_\_ Policy Holder' Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First

Policy Holder' Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Relationship to Patient (please check): ( ) self, ( ) spouse, ( ) father, ( ) mother, ( ) other \_\_\_\_\_

Address \_\_\_\_\_  
Street Address Apt City State Zip Code

Employer's Name \_\_\_\_\_ Employer's phone number (\_\_\_\_) \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street Address City State Zip Code

**– Registration Form –**

# NYC MEDICAL AND NEURODIAGNOSTIC, P.C.

## PATIENT INFORMATION CONSENT FORM

I have read and fully understand NYC Medical and Neurodiagnostic's Notice of Information Practices. I understand that NYC Medical and Neurodiagnostic may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that NYC Medical and Neurodiagnostic will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in NYC Medical and Neurodiagnostic's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

\_\_\_\_\_

\_\_\_\_\_

**Patient or Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_

**Patient or guardian signature**

## INSURANCE/PAYMENT AUTHORIZATION FORM

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
Name of Insurance Plan

and assign directly to NYC Medical & Neurodiagnostic, PC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Appropriate efforts will be made by this office to bill my insurance, workman's comp, etc. if applicable, however I understand that co-pays, deductibles, and ultimately the total amount of my bill is my responsibility and I will be expected to settle my account in a timely manner. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize to use of this signature on all insurance submissions and permit copies of this authorization to be used in place of the original. Should any balance remain after 90 days, I will pay interest at the annual rate of 12% (1% per month) starting from the date the charges were made. I understand that delinquent accounts are turned over to a collection agency. If this account is assigned to an outside agency for collection, I agree to pay all attorney fees, court costs, and a collection agency fee of 40%, which will be added to the outstanding balance of my account with or without suit.

**Patient (or responsible party)/ Guardian signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Patient's Name \_\_\_\_\_

FAMILY HISTORY			If Living		If Deceased	
	Sex	Age	Health	Age at death	Cause	
Father						
Mother						
Brothers/ Sisters (circle sex)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
Husband/ Wife						
Sons/ Daughters (circle sex)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				

Do you know of any blood relative who has or had: (Circle and give relationship)

Stroke \_\_\_\_\_ Diabetes \_\_\_\_\_ Congenital Heart \_\_\_\_\_ Rheumatic Heart \_\_\_\_\_  
 Epilepsy \_\_\_\_\_ Heart Attack \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Stomach Ulcers \_\_\_\_\_  
 Seizures \_\_\_\_\_  
 Parkinson \_\_\_\_\_ Cancer \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Goiter \_\_\_\_\_  
 Multiple Sclerosis \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Asthma \_\_\_\_\_ Arthritis \_\_\_\_\_  
 Migraine \_\_\_\_\_ Bleeding Tendency \_\_\_\_\_ Colitis \_\_\_\_\_ Mental Illness \_\_\_\_\_  
 Suicide \_\_\_\_\_

**PERSONAL HABITS:** (Circle)

Y N

- Do you use tobacco: Cigarettes/ Chew/ Cigars  
If YES: For how many years? \_\_\_\_\_ How much? \_\_\_\_\_
- Do you usually drink caffeinated beverages?  
If YES: How much? \_\_\_\_\_ How often? \_\_\_\_\_
- Do you drink alcohol?  
If YES: How much? \_\_\_\_\_ How often? \_\_\_\_\_
- Do you have difficulty in falling asleep?
- Do you awaken early in the morning without apparent cause?

Patient's Name \_\_\_\_\_

**MEDICATIONS:**

Medication Name	Dose	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ALLERGIES:**

Name any drugs to which you are allergic and the reaction you had:

\_\_\_\_\_

\_\_\_\_\_

**SURGERIES:**

List the names and year of any operations which you have had:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HOSPITALIZATIONS:**

List the names of any diseases you had which required hospitalization:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY:**

Other diagnosis (high blood pressure, diabetes, asthma, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ACCIDENT/ INJURIES:**

Serious injuries or accidents:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PRESENT ILLNESS:**

Describe briefly your present medical symptoms:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_