



NEW PATIENT REGISTRATION FORM

DATE	APPOINTMENT WITH	MR #
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PATIENT INFORMATION

PATIENT'S LAST NAME/Apellido Del Paciente	FIRST NAME/Primer Nombre	DOB	AGE/Edad	SOCIAL SECURITY #
STREET ADDRESS/Direccion	APT. #	CITY/Ciudad	STATE	ZIP CODE
COUNTRY	SEX/Sexo (CIRCLE ONE) M <input type="checkbox"/> F <input type="checkbox"/>			
HOME PHONE NO /Telephono ()	WORK PHONE NO ()	MAR <input type="checkbox"/> ST <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SP <input type="checkbox"/>	SPOUSE'S NAME	SPOUSE'S WORK NO () EXT T <input type="checkbox"/>
PATIENT EMPLOYER/Patron Del Paciente'	F/T STUDENT Y N	ALLERGIES		
EMPLOYER'S ADDRESS/Direccion Del Patron	CITY/Ciudad	STATE/Estado	ZIP CODE	
EMERGENCY CONTACT PERSON/Contacto De Emergencia	RELATIONSHIP TO PATIENT	CONTACT'S HOME PHONE NO ()	CONTACT'S WORK PHONE ()	EXT
REFERRING MD NAME	ADDRESS	CITY	STATE	ZIP CODE
PHONE NO ()				
PRIMARY DOCTOR NAME	ADDRESS	CITY	STATE	ZIP CODE
PHONE NO ()				

GUARANTOR INFORMATION - Person responsible for payment, if other than self

GUARANTOR'S LAST NAME	FIRST NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY	DOB	HOME PHONE NO ()
GUARANTOR'S ADDRESS	APT. #	CITY	STATE	ZIP CODE	COUNTRY
SEX/Sexo (CIRCLE ONE) M <input type="checkbox"/> F <input type="checkbox"/>					
GUARANTOR'S EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE NO ()

INSURANCE INFORMATION

MEDICARE	EFF. DATE	MEDICAID #	EFF. DATE
PRIMARY INSURANCE COMPANY	EFF. DATE	POLICY #	GROUP #
CERTIFICATE #			
ADDRESS	CITY	ZIP CODE	STATE
ZIP CODE	STATE	ZIP CODE	PHONE NO ()
NAME OF INSURED	PATIENT RELATIONSHIP TO INSURED	SOCIAL SECURITY #	DOB
SEX/Sexo (CIRCLE ONE) M <input type="checkbox"/> F <input type="checkbox"/>			
INSURED'S ADDRESS	APT. #	CITY	STATE
ZIP CODE	COUNTRY	HOME PHONE NO ()	
INSURED'S EMPLOYER	WORK PHONE NO ()		
SECONDARY INSURANCE COMPANY	EFF. DATE	POLICY #	GROUP #
CERTIFICATE #			
ADDRESS	CITY	ZIP CODE	STATE
ZIP CODE	STATE	ZIP CODE	PHONE NO ()
NAME OF INSURED	PATIENT RELATIONSHIP TO INSURED	SOCIAL SECURITY #	DOB
SEX/Sexo (CIRCLE ONE) M <input type="checkbox"/> F <input type="checkbox"/>			
INSURED'S ADDRESS	APT. #	CITY	STATE
ZIP CODE	COUNTRY	HOME PHONE NO. ()	
INSURED'S EMPLOYER	WORK PHONE NO. ()		

AUTHORIZATION INFORMATION

ASSIGNMENT OF BENEFITS:

I hereby assign to Shuriz Hishmeh, MD any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under my "insurance", I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR RELEASE OF INFORMATION:

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPAA Notice of Privacy Practices" information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature of Patient/Legal Guardian: _____ Date: _____



Date of Initial Visit: ____/____/____

Last Name _____

First Name _____

Age: _____ Date of Birth ____/____/____

Sex: _____ Weight: _____ Height: _____

Phone: Home _____ Work _____ Mobile _____

Email: _____

Who referred you to the Dr. Hishmeh?

Referring Physician Name _____

Referring Physician Telephone # _____

Referring Physician Address _____

City _____

State _____

Zip Code _____

Please describe your main problem/complaint. _____

PLEASE PUT AN "X" NEXT TO THE BEST ANSWER FOR EACH QUESTION

SOCIAL HISTORY

Marital Status: Single Married Divorced Separated Widowed

Highest Education Level Completed: (0, 1 2 3 4 5 6 7 8) Grade school (9 10 11 12) High school (13 14 15 16) College, Technical (> 16 YEARS) Graduate, Professional

Do you currently use Tobacco? Yes No If No, Did you Ever Smoke? Yes No

Indicate quantity per day: Cigarettes _____ Cigars _____ Chewing Tobacco _____

Do you currently consume Alcohol? Yes No

Indicate quantity per day: Beer _____ Wine _____ Distilled Spirits _____

WORK STATUS

Occupation

Are you currently?

- | | | | |
|--------------------------|-----------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | Working Full time | <input type="checkbox"/> | Working Part time |
| <input type="checkbox"/> | Unemployed | <input type="checkbox"/> | Retired |
| <input type="checkbox"/> | Disabled, Temporarily | <input type="checkbox"/> | Disabled, Permanently |
| <input type="checkbox"/> | Housewife | <input type="checkbox"/> | Other _____ |

If you are currently NOT working:

How long have you been off work due to your back/neck pain? _____





PAST MEDICAL HISTORY - Check below if you have had any of the following:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> NONE
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Emotional Disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV	
<input type="checkbox"/> OTHER _____			

Current Medications (include Non-Prescription): _____

Medicine / Substance Allergies (include Reaction): _____

CURRENT MEDICAL CONDITION:

Do you have:

<input type="checkbox"/> Only back pain	<input type="checkbox"/> Only leg pain
<input type="checkbox"/> Back and leg pain	<input type="checkbox"/> Only neck pain
<input type="checkbox"/> Only shoulder pain/arm pain	<input type="checkbox"/> Neck, shoulder and arm pain
<input type="checkbox"/> Other _____	

Which is worse:

<input type="checkbox"/> Back pain	<input type="checkbox"/> Leg pain
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Shoulder/arm pain

I have had back/neck pain:

<input type="checkbox"/> Less than 1 month	<input type="checkbox"/> 1 - 3 Months
<input type="checkbox"/> 3 - 6 Months	<input type="checkbox"/> 6 Months - 1 Year
<input type="checkbox"/> 1 - 3 Years	<input type="checkbox"/> 3 - 5 Years
<input type="checkbox"/> Greater than 5 years	

My pain came on:

<input type="checkbox"/> Gradually, over time	<input type="checkbox"/> Quickly
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My pain was brought on by:

<input type="checkbox"/> No specific incident
<input type="checkbox"/> Following an accident or incident at work
<input type="checkbox"/> Following an accident or incident <u>NOT</u> at work

Describe the accident/incident: _____

Do you have:

<input type="checkbox"/> NUMBNESS	Where _____
<input type="checkbox"/> TINGLING	Where _____
<input type="checkbox"/> WEAKNESS	Where _____

What time of the day is your pain worse: Morning Late in the day The middle of the night

My pain pattern is:

<input type="checkbox"/> A Single attack of pain	<input type="checkbox"/> Attacks of pain with pain free intervals
<input type="checkbox"/> Continuous pain	<input type="checkbox"/> Continuous pain with attacks of severe pain

I experience pain:

<input type="checkbox"/> The entire day
<input type="checkbox"/> Most of the day (16-20 HOURS)
<input type="checkbox"/> A Good part of the day (8-15 HOURS)
<input type="checkbox"/> A Fair amount of the day (2-7 HOURS)
<input type="checkbox"/> A Small amount of the day (1 HOUR OR LESS)
<input type="checkbox"/> Less than once per day



How long does a pain attack last:
Constant

Seconds Minutes Hours _____

For how long can you walk:

Less than 15 minutes 15 - 30 Minutes
 30 - 60 Minutes NO Restrictions

How long can you sit:

Less than 15 minutes 15 - 30 Minutes
 30 - 60 Minutes NO Restrictions

How long can you stand:

Less than 15 minutes 15 - 30 Minutes
 30 - 60 Minutes NO Restrictions

What position/activity make the pain worse or better?

	Better	Worse	Comments		Better	Worse	Comments
Standing				Bending			
Sitting				Lifting			
Walking				Coughing			
Stairs				General Activity			
Lying Down				Bowel Movement			

Pain Rating Scale: How would you rate your pain today: (Circle One Number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain
None Mild Moderate Severe

Where have you sought help for your pain: (Check all that apply)

Family Doctor Physical Therapist Physiatrist
 Orthopedic Doctor Neurologist Chiropractor
 Spine Surgeon Psychiatrist / Psychologist Pain Clinic
 OTHER _____

Have any of the above decreased your pain: NO YES Specify _____

My pain now seems to be: Getting better Staying the same Getting worse

Have you noticed any change in your bowel or bladder habits:

NO YES Describe: _____

Have you had previous Surgery:

YES WHEN: ___/___/___ TYPE: _____
 NO WHEN: ___/___/___ TYPE: _____
WHEN: ___/___/___ TYPE: _____

If you had previous spine surgery, did the surgery make the pain better: YES NO

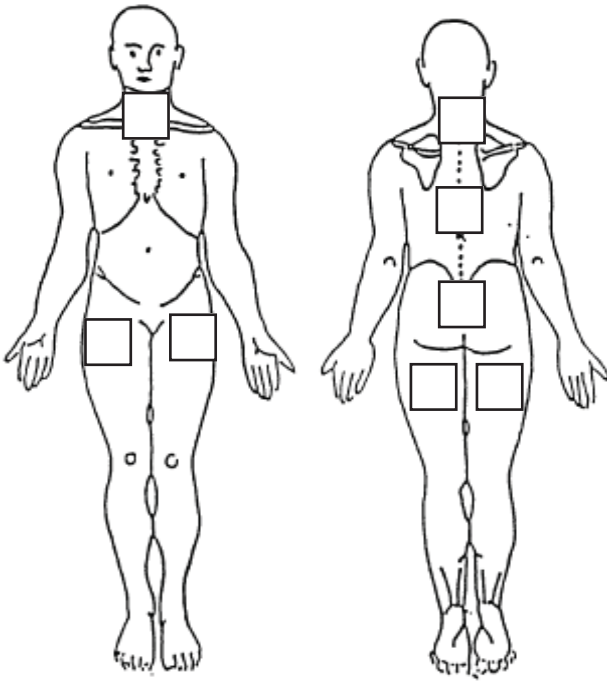
Have you, or are you planning to apply for disability or workmen's compensation: YES NO

Is there a lawsuit or litigation pending in relationship to your pain? YES NO

-- FOR OFFICE USE ONLY --

Patient/Family Education Record:

Learner: π Patient π Family π Other _____ Learning Needs: πTreatments π Medications π Disease Process π Pain π Other _____
Barriers: π None π Physical π Language π Cultural/Religious π Financial π Cognitive π Psychosocial
Methods: πDiscussion π Demonstration π Handout π Other _____ Follow Up Plan: π Review π Other _____
Comprehension: πVerbalized Understanding πReturn Demonstration π Other _____ Signature: _____



PAIN DIAGRAM:

Please use the following diagrams to show us where you are experiencing pain and numbness:

Pain: x x x x x x

Numbness: o o o o o o o

Aching: / / / / / /

Please circle all of the following adjectives which describe your pain:

- DULL
- COLD
- TIGHT
- ELECTRIC
- OTHER _____
- BURNING
- SHOOTING
- THROBBING
- TINGLING

Patients with Scoliosis or Kyphosis, please complete the next section.

SCOLIOSIS / KYPHOSIS SECTION

Year deformity was first noticed: _____

Your age at the time deformity was first noticed: _____

Family history of Scoliosis/ Kyphosis:

<input type="checkbox"/> None	<input type="checkbox"/> Parent
<input type="checkbox"/> Brother/ Sister	<input type="checkbox"/> Cousin
<input type="checkbox"/> Other _____	

Previous non-operative treatment:

<input type="checkbox"/> None	<input type="checkbox"/> Exercise
<input type="checkbox"/> Brace	<input type="checkbox"/> Observation only
<input type="checkbox"/> Other _____	

First operative event: ____ / ____ / ____ Second operative event: ____ / ____ / ____

Current concerns:

<input type="checkbox"/> None	<input type="checkbox"/> Feel imbalance
<input type="checkbox"/> New or increased back pain	<input type="checkbox"/> Painful rod
<input type="checkbox"/> Unhappy with my appearance	

If you have back pain, then where: Upper back Mid back Lower back

Do you feel that your curves have increased or decreased over time: Yes No

Do you feel you have lost height in the last few years: Yes No

*** END OF QUESTIONNAIRE ***



**PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION (HIPAA)**

I hereby give my consent for Shuriz Hishmeh, MD, PLLC to use and disclose protected health information (“*PHI*”), as that term is defined by the Health Insurance Portability and Accountability Act (“*HIPAA*”), about me to carry out treatment, payment and healthcare operations (“*TPO*”) (Shuriz Hishmeh, MD, PLLC’s Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Shuriz Hishmeh, MD, PLLC reserves the right to revise its Notice of Privacy Practices at any time without prior notice to you. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Shuriz Hishmeh, MD, PLLC at 175 Jericho Turnpike, Suite 120, Syosset, New York 11791.

With this consent, Shuriz Hishmeh, MD, PLLC may call my home, cell phone, or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. Calls may be made by a live person or automated system.

With this consent, Shuriz Hishmeh, MD, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Shuriz Hishmeh, MD, PLLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Shuriz Hishmeh, MD, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Shuriz Hishmeh, MD, PLLC 's use and disclosure of my PHI to carry out TPO. I may only revoke my consent in writing except however cannot restrict the practice’s disclosures made in reliance of my prior consent. If I do not sign this consent, or later revoke it, Shuriz Hishmeh, MD, PLLC may decline to provide treatment to me.

(Print name of Patient)

(Signature of Patient)

(Date of signature)



**PATIENT FINANCIAL RESPONSIBILITY AND
INSURANCE AUTHORIZATION
AND ASSIGNMENT FORM**

You are responsible for all professional services rendered by Shuriz Hishmeh, MD, PLLC. Dr. Hishmeh is not a provider for any private insurance carrier. If we do not accept your insurance plan, the necessary forms will be completed by our office to help expedite insurance carrier payments. However, as the patient, you are ultimately responsible for all of our fees. By signing this form, you hereby authorize the doctors at Shuriz Hishmeh, MD, PLLC, its agents, employees or assigns, including its billing company, to diagnose, treat and manage the medical condition(s) presented at the time of your visit and to furnish any information to the insurance carriers concerning your illness and treatments. You hereby assign all insurance payments to Shuriz Hishmeh, MD, PLLC for medical services rendered to you personally or to your dependents and understand that you are responsible for any amount that is not a covered service under my insurance.

I understand and agree that health and accident policies are a contract between the insurance carrier and me. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

While it is customary to pay when services are rendered unless other arrangements have been made in advance with our office, as a courtesy to you, Shuriz Hishmeh, MD, PLLC will allow you to make payment for your treatment once checks have been issued by your insurance company are received by you. Please note that although the checks are for services that were rendered by Shuriz Hishmeh, MD, PLLC, payment from the insurance carrier may be issued in your name, or the name of the primary policy holder. Should that occur, all you need to do is bring the checks and accompanying paperwork to this office. Please direct family members or others who may have access to your mail not to deposit or cash the checks. By signing this form you agree to bring all payments from your insurance company received for services/treatment rendered by Shuriz Hishmeh, MD, PLLC to our office.

If we are required to refer your account to a collection agency for any reason, your account balance will be charged a fee of twenty-five (25%) percent. In the event that your account is referred to an attorney, you will pay all legal fees and third-party expenses charged by the attorney. I consent to receive calls from this office and from Dr. Hishmeh's billing company, and if needed, collectional agency or legal counsel, and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

I _____ affirm that I have read, understand and agree to the following the above policies of Shuriz Hishmeh, MD, PLLC.

Signature: _____

Date: _____