SEAN E. McCANCE, M.D.
Spine Surgery

1155 Park Avenue • New York, NY 10128
Telephone: 212/360-6500 • Facsimile: 212/360-6535

Date: ______________

Name: (print) ______________________________ Age: ________ Birth date: ______________

Home address: ______________________________ Phone: ______________

Apt: ______ City: ______________ State: ________ Zip Code: ______________

Marital Status: ______ Occupation: ______________ Cell Phone: ______________

E-mail Address: ______________________________

Patient's Social Security # ______________________________

Name of Employer: ______________________________

Business Address: ______________________________ Phone: ______________

City: ______________ State: ______________ Zip Code: ______________

Name & Address of person to be billed: ______________________________

In case of an emergency contact name & number: ______________________________

Family Doctor: ______________________________

Address: ______________________________ Phone: ______________

Referring doctor or person: ______________________________

Address: ______________________________ Phone: ______________

Insurance Information:

	Company Name/Address	**Policy #**	**Group #**
Primary:			

Secondary: ______________________________ Medicare # ______________

Policy Holder's Name ______________ DOB ______________ SS# ______________

Policy Holder's Employer: ______________________________

Signature: ______________________________ **Date:** ______________

Name: ______________________ Date: ______________

List your main complaint: ______________________

When started: ______________ How? ______________

Detail your progress: ______________________

Treatments you've had: ______________________

Past Medical History:

Medical Illnesses: ______________________

Drug Allergies: __________ Smoke? __________ Drink? __________

Regular medications: ______________________

Previous Surgeries: ______________________

Review of Systems:

Check off any complaints that you have had:

Sleep apnea: ____

Diabetes: ____ High blood pressure: ____ Heart Attack: ____ Stroke: ____

Cancer: ____ Kidney: ____ Cholesterol: ____ Thyroid: ____ Liver: ____

Intestinal: ____ Ulcer: ____ Bleeding Disorder: ____

Headaches: ____ Visual Disorder: ____ Hearing Disorder: ____

Bladder: ____ Sexual Dysfunction: ____ Prostate: ____ Breast: ____

Hip: ____ Knee: ____ Ankle: ____ Gout: ____

Shoulder: ____ Elbow: ____ Wrist: ____

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PETER FRELINGHUYSEN, M.D.
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PATIENT AUTHORIZATION TO DISCLOSE INFORMATION TO SPECIFIC INDIVIDUALS

(GW&T # 273300.0-Under "Disclosure for Patients Chart")

I, ____, hereby authorize my physician and/ or his/her
(CLEARLY PRINT YOUR NAME)
representatives to disclose medical and financial/billing/insurance information to the individual(s) listed below:

Name of Approved	Relationship	Timeframe
1.		
2.		
3.		
4.		

PLEASE CHECK OFF* THE APPROPRIATE AUTHORIZATION AND/OR LIMITATION FOR THE ABOVE INDIVIDUAL(S). (NOTE TO THE PATIENT: **IF YOU DO NOT WANT STAFF MEMBERS TO BE AUTHORIZED TO DISCLOSE YOUR MEDICAL INFORMATION TO THE AUTHORIZED INDIVIDUAL(S), PLEASE CHECK OFF THE APPROPRIATE LINE DIRECTLY).**

_______ I do not limit this information to a specific timeframe. The practice may disclose past, present and future information to the above name (d) individual(s).

_______ I limit this authorization to the dates noted under "timeframe".

_______ I only authorize my physician, not his representative/staff, to disclose my medical information. I understand that in my physician's absence, one of his partners and/or physician assistant will need to speak to the individual(s) listed above.

______________________________ (Patient's Signature) ______________ (Date)

______________________________ (Witness' Signature) ______________ (Date)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly
2. Obtain payment from third-party payers
3. Conduct normal health operations such as quality assessment and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, you are bound to abide by such restrictions.

Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________

....

OFFICE USE ONLY

I attempted to obtain the patient signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:____________ Initials: ______________ Reason:______________________________

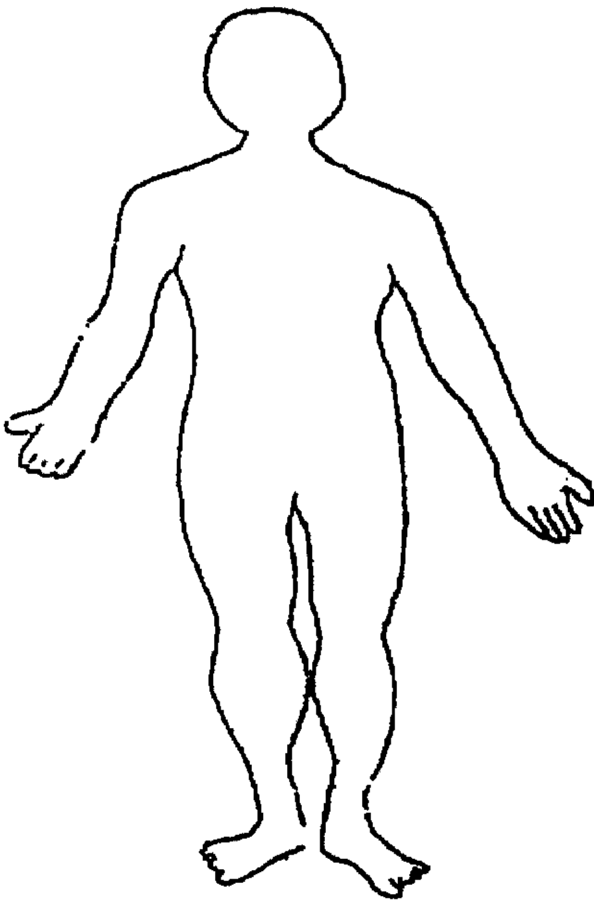
Spine Associates

PATIENT PAIN DRAWING

Name:______________________________________ Date:_______________________

Mark the areas of your body where you feel the sensations listed below, using the appropriate symbol.
For example, put X's where you feel the burning.
Mark any areas where the sensation radiated to, so the picture includes all affected areas.
To complete the picture, please draw in your face.

ACHING	NUMBNESS	PINS/NEEDLES	BURNING	STABBING
>>>>>>	= = = = = =	^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^	XXXXXXXX	/////////////



SA