Chart:

FRANK P. CAMMISA, JR., M.D.
ANDREW A. SAMA, M.D.
ALEX P. HUGHES, M.D.

Spinal Surgery
EAST RIVER PROFESSIONAL BUILDING
523 EAST 72ND STREET, 3rd Floor
NEW YORK, NY 10021

PATIENT INFORMATION

Today's Date: _____ Appt Date: _____ Chart # _____

Name: _____ Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Cell: _____

Home Telephone: _____ Business Telephone: _____

Employer: _____ Address: _____

Age: _____ Date of Birth: _____ Social Security No.: _____

Occupation: _____ Date Disability Began: _____

Work Status: Regular _____ Light Work _____ Totally Disabled _____

Marital Status: M S W D

Referring Physician (**address and telephone**): _____
Have you seen this MD? yes no

Name AND address of physicians who will need copies of your medical report:
Without correct addresses, the report will be returned to you for processing.

_____

If Minor - Names of Parents: _____

Person to Contact in and Emergency (include phone and relationship):

_____

Compensation Case? _____ Auto Accident? _____ Registration State _____

Comp or Auto Insurance Carrier (Address and Telephone): _____

DO NOT MAIL THIS FORM. IT MUST BE GIVEN TO THE DOCTOR.

Chart:

30-20

WCB/NF POLICY HOLDER: _____ POLICY NO: _____
CARRIER CASE NUMBER: _____ WCB NUMBER: _____

HOSPITAL AND MAJOR MEDICAL INSURANCE

MAJOR MEDICAL COMPANY (doctor's coverage) (address, policy/group number): _____

_____

HOSPITAL INSURANCE (address, policy/group number): _____

_____

__ I have not hospitalization insurance / I have no major medical

DATE OF INJURY / ONSET OF SYMPTOMS: _____ Lawsuit Pending*: yes no

*Should any litigation arise, it is understood and agreed that the treating physician will not participate in any way in litigation except to provide true and accurate copies of any medical records in possession.

X _____ Signature of Patient

Credit Card Authorization- I authorize, when requested by me **over the phone**, use of my credit card for outstanding charges.

Fee for the initial consultation is: $600.00 This fee does not apply to patients who are covered by Medicare, Workmen's Compensation, No Fault and participating managed care plans. This charge is for the doctor's consultation only. It does not include X-Rays or other services which may be rendered. We do not accept assignment of insurance. This fee is payable ON THE DAY OF YOUR VISIT.

Delinquent payment fee, collection cost and attorneys fee:

It is understood that the patient or other responsible party shall pay Dr. Cammisa / Dr. Sama / Dr. Hughes within thirty days after receipt of a bill from Dr. Cammisa / Dr. Sama / Dr. Hughes stating that the balance is due. In the event that full payment is not made within thirty-five days of the mailing of said bill, unless agreed in writing to the contrary, the patient or other responsible party will be charged an interest rate of 9% per annum on all accounts not paid in full by the due date. If the delinquent balance is not paid in a timely manner after the final due date, and the doctor employs a collection agency or attorney, you will be required to pay collection fees and other related costs, including reasonable attorneys' fees, in addition to your balance due, plus interest as aforesaid.

Relevant state laws shall govern this understanding. Further, you agree that in any action to collect payment hereunder, you hereby waive your right to trial by jury and the right to interpose counterclaims in any action brought for enforcement of the agreement. You may bring separate action for any disputes you may have with the doctor related to the contract or otherwise.

X-Rays left at the office and X-rays taken at The Hospital for Special Surgery are stored together at the hospital (600-1134). X-Rays are not stored in our office.

Please note that during the course of your treatment, there will be occasionally be the need for conferences with other doctors, phone consultations with and regarding you, and the like. For this purpose we retain your signature on file authorizing us to bill your insurance carrier for these efforts. You are NOT billed directly for additional consulting services performed out of the context of your visit to us. **Please bring insurance forms, completed and signed, with you for this purpose.**

I request that payment of authorized **MEDICARE** benefits and all insurances be made either to me or on my behalf to Dr. Cammisa / Dr. Sama / Dr. Hughes for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for **MEDICARE** and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I authorize insurance payments be made directly to Dr. Cammisa / Dr. Sama / Dr. Hughes

Policy Holder's Name: _____ Date: _____

Policy Holder's Signature _____ Date: _____

Guarantor Signature: _____ Date: _____

Chart:

30-30

FRANK P. CAMMISA JR. M.D., F.A.C.S
ANDREW A. SAMA M.D.
ALEXANDER P. HUGHES M.D.

EAST RIVER PROFESSIONAL BUILDING
523 EAST 72ND STREET, 3rd Floor
NEW YORK, NY 10021
--
Telephone: 212/606-1946

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also agree that **Frank P. Cammisa, JR., M.D., P.C.** may request to use my prescription medication history from other healthcare providers or 3rd party pharmacy benefit payors for treatment purposes. Any health information disclosed pursuant to this authorization may be subject to redisclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Patient Name: _____ Social Security: (last 4 digits only) _____

Persons/Organizations authorized to use, disclose, or receive my information:

_____

_____

_____

Specific description of the information to be used and disclosed (including date(s)):

_____

_____

Description of each purpose regarding the use or disclosure of my health information:

At the request of the patient.

I understand that this authorization will expire on: _____ Initials _____

I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form, Initials _____

I understand that I will get a copy of this form after I sign it. Initials _____

I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on the actions the Practice has already taken in reliance on this authorization. Initials _____

_____ _____
Signature of patient Date

If this authorization is signed by a patient's representative, please complete the following:

_____
Printed name of patient's representative

_____
Relationship to the patient

Chart: **30**

30-28

OSWESTRY DISABILITY INDEX

This questionnaire is designed to give your clinician/physician information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark only the ONE box which best applies to you at this moment.

Name: _____ Date: 1/23/2019

□ Baseline □ 6 weeks □ 3 months □ 6 months □ 1 year □ 2 years □ Other _____

SECTION 1 – PAIN INTENSITY
- □$_0$ I have no pain at the moment
- □$_1$ The pain is very mild at the moment.
- □$_2$ The pain is moderate at the moment.
- □$_3$ The pain is fairly severe at the moment.
- □$_4$ The pain is very severe at the moment.
- □$_5$ The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)
- □$_0$ I can look after myself normally without causing extra pain.
- □$_1$ I can look after myself normally but it is very painful.
- □$_2$ It is painful to look after myself and I am slow and careful.
- □$_3$ I need some help but manage most of my personal care.
- □$_4$ I need help every day in most aspects of self care.
- □$_5$ I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – LIFTING
- □$_0$ I can lift heavy weights without extra pain.
- □$_1$ I can lift heavy weights but it gives extra pain.
- □$_2$ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- □$_3$ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □$_4$ I can lift only very light weights.
- □$_5$ I cannot lift or carry anything at all.

SECTION 4 – WALKING
- □$_0$ Pain does not prevent my walking any distance.
- □$_1$ Pain prevents me walking more than 1 mile.
- □$_2$ Pain prevents me walking more than ½ of a mile.
- □$_3$ Pain prevents me walking more than 100 yards.
- □$_4$ I can only walk using a stick or crutches.
- □$_5$ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – SITTING
- □$_0$ I can sit in any chair as long as I like.
- □$_1$ I can sit in my favorite chair as long as I like.
- □$_2$ Pain prevents me from sitting for more than 1 hour.
- □$_3$ Pain prevents me from sitting more than ½ an hour.
- □$_4$ Pain prevents me from sitting more than 10 minutes.
- □$_5$ Pain prevents me from sitting at all.

SECTION 6 – STANDING
- □$_0$ I can stand as long as I want without extra pain.
- □$_1$ I can stand as long as I want but it gives me extra pain.
- □$_2$ Pain prevents me from standing for more than 1 hour.
- □$_3$ Pain prevents me from standing for more than ½ an hour.
- □$_4$ Pain prevents me from standing for more than 10 minutes.
- □$_5$ Pain prevents me from standing at all.

SECTION 7 – SLEEPING
- □$_0$ My sleep is never disturbed by pain.
- □$_1$ My sleep is occasionally disturbed by pain.
- □$_2$ Because of pain I have less than 6 hours sleep.
- □$_3$ Because of pain I have less than 4 hours sleep.
- □$_4$ Because of pain I have less than 2 hours sleep.
- □$_5$ Pain prevents me from sleeping at all.

SECTION 8 – SEX LIFE
- □$_0$ My sex life is normal and causes no extra pain.
- □$_1$ My sex life is normal but causes some extra pain
- □$_2$ My sex life is nearly normal but is very painful.
- □$_3$ My sex life is severely restricted by pain.
- □$_4$ My sex life is nearly absent because of pain.
- □$_5$ Pain prevents any sex life at all.

SECTION 9 – SOCIAL LIFE
- □$_0$ My social life is normal and causes me no extra pain.
- □$_1$ My social life is normal but increases the degree of pain.
- □$_2$ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sports, etc.
- □$_3$ Pain has restricted my social life and I do not go out as often.
- □$_4$ Pain has restricted my social life to my home.
- □$_5$ I have no social life because of pain.

SECTION 10 – TRAVELING
- □$_0$ I can travel anywhere without pain.
- □$_1$ I can travel anywhere but it gives extra pain.
- □$_2$ Pain is bad, but I manage journeys over 2 hours.
- □$_3$ Pain restricts me to journeys of less than 1 hour.
- □$_4$ Pain restricts me to short necessary journeys under 30 min.
- □$_5$ Pain restricts me from traveling except to receive treatment.

HOSPITAL FOR SPECIAL SURGERY

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Version 2.0

Chart: **30**

* 3 0 - 2 8 *

NECK DISABILITY INDEX

This questionnaire is designed to give your clinician/physician information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark only the ONE box which best applies to you at this moment.

Name: _____ Date: 1/23/2019

□ Baseline □ 6 weeks □ 3 months □ 6 months □ 1 year □ 2 years □ Other _____

SECTION 1 – PAIN INTENSITY
- □0 I have no pain at the moment
- □1 The pain is very mild at the moment.
- □2 The pain is moderate at the moment.
- □3 The pain is fairly severe at the moment.
- □4 The pain is very severe at the moment.
- □5 The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)
- □0 I can look after myself normally without causing extra pain.
- □1 I can look after myself normally but it is very painful.
- □2 It is painful to look after myself and I am slow and careful.
- □3 I need some help but manage most of my personal care.
- □4 I need help every day in most aspects of self care.
- □5 I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – LIFTING
- □0 I can lift heavy weights without extra pain.
- □1 I can lift heavy weights but it gives extra pain.
- □2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- □3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □4 I can lift only very light weights.
- □5 I cannot lift or carry anything at all.

SECTION 4 – READING
- □0 I can read as much as I want to with no pain in my neck.
- □1 I can read as much as I want to with slight pain in my neck.
- □2 I can read as much as I want with moderate neck pain.
- □3 I can't read as much as I want because of moderate neck pain.
- □4 I can hardly read at all because of severe pain in my neck.
- □5 I cannot read at all.

SECTION 5 – HEADACHES
- □0 I have no headaches at all.
- □1 I have slight headaches which come infrequently.
- □2 I have moderate headaches which come infrequently.
- □3 I have moderate headaches which come frequently.
- □4 I have severe headaches which come frequently.
- □5 I have headaches almost all the time.

SECTION 6 – CONCENTRATION
- □0 I can concentrate fully when I want to with no difficulty.
- □1 I can concentrate fully when I want to with slight difficulty.
- □2 I have a fair degree of difficulty in concentration when I want to.
- □3 I have a lot of difficulty in concentrating when I want to.
- □4 I have a great deal of difficulty in concentrating when I want to.
- □5 I cannot concentrate at all.

SECTION 7 – SLEEPING
- □0 I have no trouble sleeping.
- □1 My sleep is slightly disturbed (less than 1 hr. sleepless).
- □2 My sleep is mildly disturbed (1-2 hrs. sleepless).
- □3 My sleep is moderately disturbed (2-3 hrs. sleepless).
- □4 My sleep is greatly disturbed (3-5 hrs. sleepless).
- □5 My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 8 – DRIVING
- □0 I can drive my car without any neck pain.
- □1 I can drive my car as long as I want with slight pain in my neck.
- □2 I can drive my car as long as I want with moderate pain in my neck.
- □3 I can't drive my car as long as I want because of moderate pain in m neck.
- □4 I can hardly drive at all because of severe pain in my neck.
- □5 I can't drive my car at all because of severe pain in my neck.

SECTION 9 – WORK
- □0 I can do as much work as I want to.
- □1 I can only do my usual work, but no more.
- □2 I can do most of my usual work, but no more.
- □3 I cannot do my usual work.
- □4 I can hardly do any work at all.
- □5 I cannot do any work at all.

SECTION 10 – RECREATION
- □0 I am able to engage in all of my recreational activities with no neck pain at all.
- □1 I am able to engage in all of my recreational activities with some pain in my neck.
- □2 I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- □3 I am able to engage in a few, but not all of my recreational activities because of pain in my neck.
- □4 I can hardly do any recreational activities because of the pain in my neck.
- □5 I cannot do any recreational activities at all because of the pain in my neck.

HOSPITAL FOR SPECIAL SURGERY

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Name:
Chart:
Date:

30-20

Name: _____ Date: _____

Age: _____

Please circle one: Left hand dominant Right hand dominant Ambidextrous

Previous spinal surgery (*Include date, procedure, names of surgeons, results and/or complications):

List your primary symptoms in order of importance (i.e. low back pain, neck pain, headaches, arm/leg weakness, sensation changes, imbalance, etc):

1) _____

2) _____

3) _____

Do you have any of the following symptoms (if yes, please write location, severity, pertinent details):

Weakness: _____

Numbness: _____

Pins & Needles: _____

Balance Impairment: _____

Gait disturbance (i.e. limping, leaning forward, etc.): _____

Bowel or bladder dysfunction: _____

Date of onset of symptoms (Please describe any trauma/injury, motor vehicle accident, gradual, etc.):

Surgeons or other doctors seen for this condition:

Any history of spine problems prior to current symptoms: (If yes, please give brief history)

Name:
Chart:
Date:

30-20

Have you had any of the following treatments for these symptoms (include dates, number of sessions, injections, etc. and please indicate if these were helpful):

Epidural Steroid Injections: _____

Facet Injections: _____

Trigger Point Injections: _____

Physical Therapy: _____

Chiropractic Care: _____

Acupuncture: _____

Oral Steroids (i.e. Prednisone, Medrol 6-day pack): _____

Other Treatments (please describe): _____

List tests taken with date: (X-rays, MRI, CT, Myelogram, Discogram, EMG, Bone Scan)

_____

_____

_____

Have you had a fracture or broken bone over the age of 50? _____ Yes _____ No

Do you take Vitamin D and Calcium? _____ Yes _____ No

If you have pain, please complete the following two questions:

Please rate your current pain on a scale of 0-10, with 0 being no pain and 10 being so severe that you could not live with it for more than a few minutes:

_____ Back _____ Right buttock/leg _____ Left buttock/leg

_____ Neck _____ Right arm _____ Left arm

Which of the following aggravate your pain (Please check those that apply):

_____ Sitting _____ Standing _____ Walking

_____ Driving _____ Lying flat on back _____ Lying flat on stomach

_____ Changing positions (i.e. rising from sitting to standing, rolling over in bed)

_____ Bending (i.e. brushing teeth over sink)

_____ Pushing an object (i.e. heavy door, vacuum cleaner)

_____ Coughing, sneezing, bearing down (Valsalva)

Do your symptoms affect your ability to fall or stay asleep? (Please check yes or no)

_____ Yes _____ No

Are symptoms worse at a particular time of day? (If so, please check):

_____ Upon rising in the morning _____ At the end of the day _____ During the night

Is your condition:

_____ Getting worse over time _____ Getting better since initial onset _____ The same over time

Name:
Chart:
Date:

PAST MEDICAL HISTORY

Are you currently having or have you had any of the following conditions (check all that apply):

_____ Heart Attack	_____ Diabetes	_____ Urinary Problems
_____ Seizure	_____ Stomach Ulcers	_____ Gout
_____ Stroke	_____ IBS	_____ Lupus
_____ Asthma	_____ Thyroid Issues	_____ Cancer
_____ COPD	_____ Osteoporosis	_____ Anemia
_____ Emphysema	_____ Osteopenia	_____ Clotting/Bleeding Disorder
_____ Pneumonia	_____ Rheumatoid Arthritis	_____ Anxiety
_____ High Blood Pressure	_____ Hepatitis/Liver Disease	_____ Depression
_____ High Cholesterol	_____ HIV	_____ Glaucoma/Cataracts
_____ Acid Reflux/GERD	_____ Tuberculosis	_____ Migraines/Headaches

_____ Other: _____

PREVIOUS SURGERIES (Please include date)

CURRENT MEDICATIONS (Please include prescription drugs, over-the-counter medications, vitamins, and supplements)

Medication:	Reason for taking:	Dose	Frequency:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

(If more medications, please attach separate medication list with all information)

Name:
Chart:
Date:

MEDICATION ALLERGIES
Please list allergies: Reaction:

SOCIAL HISTORY
Please check one of the following options:

_____ Single _____ Married _____ Divorced _____ Widowed

Patient accompanied at visit by: _____

Occupation: _____

Recreational Activities/Hobbies: _____

Do you smoke? _____ Yes _____ No _____ Quit (Date: _____)

If yes or any history of smoking, number of packs per day? _____

How many years have you smoked in total? _____

Do you drink alcohol? _____ Yes _____ No _____ Quit (Date: _____)

If yes, number of drinks per week on average? _____

(1 drink = 12 oz beer, 5 oz of wine, 1.5 oz hard liquor)

FAMILY HISTORY
Have any immediate family members been diagnosed with the following conditions (please check box and list relationship to individual):

	Yes	No	Relationship
Spinal Disorders	_____	_____	_____
Muscle/Nerve Disorders	_____	_____	_____
Rheumatoid Arthritis	_____	_____	_____
Diabetes	_____	_____	_____
Cancer	_____	_____	_____
Other	_____	_____	_____

Name:
Chart:
Date:

30-20

THIS PAGE TO BE COMPLETED BY CLINICIAN OR M.D. AT TIME OF VISIT

REVIEW OF SYSTEMS

General _____

Skin _____

Neurological _____

HEENT _____

Cardiovascular _____

Pulmonary _____

Gastrointestinal _____

Urinary _____

Renal _____

Hepatic _____

Other _____

PHYSICAL EXAM

VITAL SIGNS:

BP	**HR**	**RR**	**Temp**	**Height**	**Weight**

Gen:	[ ] well developed/well nourished	[ ] no acute distress
Neuro:	[ ] NC/AT	[ ] PERRL
	[ ] CTA b/l	[ ] No W/R/R
	[ ] RRR	[ ] No M/R/G
Abd:	[ ] NT/ND	[ ] Positive bowel sounds
Ext:	[ ] No edema	[ ] < 2 cap refill
Derm:	[ ] No ulcers/rashes	

Chart:

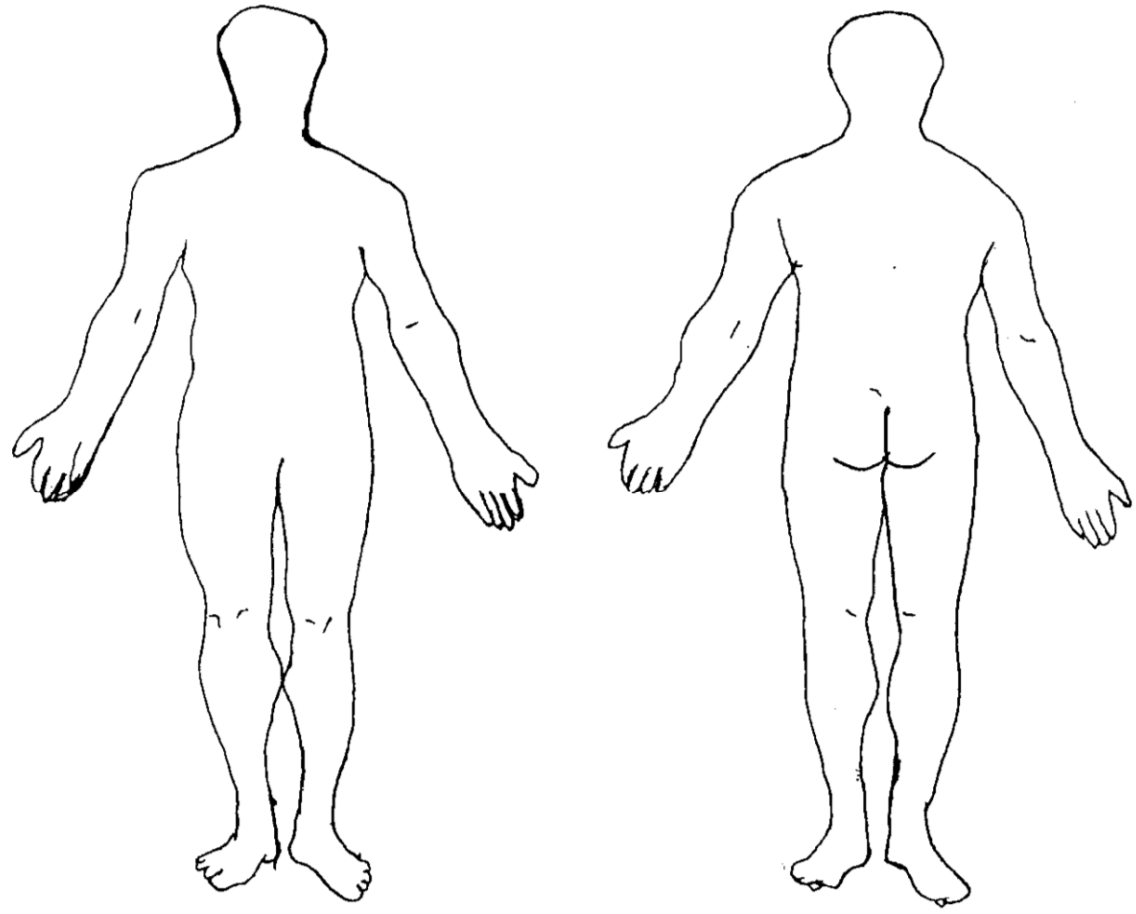
30-20

PATIENT PAIN DRAWING

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
Mark the areas of radiation, include all affected areas. To complete the picture, please draw in your face.

Aching	Numbness	Pins/Needles	Burning	Stabbing
>>>>	= = = =	|||||||	xxxxx	///////



How bad is your pain now?

Please mark with an X on the body form where the pain is worst now.

Please mark on the line below how bad your pain is now.

No Pain _____ ***Worst Possible Pain*** _____

Chart:

This page to be completed by M.D. at time of visit.

30-20

CHIEF COMPLAINT **EXAMINATION** **Init:** _____

Date dict: _____

Neck **Back**

Pain

Loc

Numb

P/N

Weak

B/B Sx

B/Gait

Lher
Spur
Abd

Val

NP

Pos
Walk
Stand
Sit
Sup
Prone
Drive
Sleep
Work
Rec

	Neck *Right*	*Left*	**Back** *Right*	*Left*	
Reflexes					
	B	_____|_____	_____|_____		K
	T	_____|_____	_____|_____		A
	BR	_____|_____	_____|_____		Clo
	Hof	_____|_____	_____|_____		Bab
	IRR	_____|_____			
Sensation					
	C5	_____|_____	_____|_____		L2
	C6	_____|_____	_____|_____		L3
	C7	_____|_____	_____|_____		L4
	C8	_____|_____	_____|_____		L5
	T1	_____|_____	_____|_____		S1
	TR	_____|_____			
Power					
	D	_____|_____	_____|_____		HF
	B	_____|_____	_____|_____		HA d
	WE	_____|_____	_____|_____		Q
	T	_____|_____	_____|_____		TA
	WF	_____|_____	_____|_____		EHL
	FE	_____|_____	_____|_____		Hab
	GR	_____|_____	_____|_____		Hex
	Fab	_____|_____	_____|_____		GS
			_____|_____		Hams

Heel Raise	List	Gower
TW/HW	SLR	FF
Lhermitte's	CLSR	EX
Spurling	Bowstring	Gait
Shoulder	FST	Pulse
Crpl Tnl	Prone	Rectal
Cubt Tnl	Stairs	
Hip		
SNt		

NSAID	TPI	Acupuncture
Analgesics	FI	Brace
OS	PT	Pain Clinic
ESI	Chiropractic	EMG

DX:

RX: Surgical

Conservative:

Tests:

X-Rays	_____
Bonescan	_____
CT	_____
MRI	_____
Myelogram	_____
EMG	_____
Discogram	_____
Other	_____

Chart: **30**

* 3 0 - 2 8 *

SF-12 (version 1) Health Survey

Patient Name: _____ Date: _____ Chart#: **30**

Visit Type: ☐ Pre-op ☐ 6 weeks ☐ 3 months ☐ 6 months ☐ 12 months

☐ 18 months ☐ 24 months ☐ Other (Specify) _____

This survey asks for your views about your health. This information will help track of how you feel and how well you are able to do your usual activities. Answer each question by choosing **one answer. If you are unsure how to answer a question, please give the best answer you can.**

1. In general, would you say your health is: (mark one response)

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (mark one on each line)

		Yes, limited a lot	Yes, limited a little	No, not limited at all
2.	Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	☐	☐	☐
3.	Climbing several flights of stairs.	☐	☐	☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (mark one on each line)

		Yes	No
4.	Accomplished less than you would like	☐	☐
5.	Were limited in the kind of work or other activities.	☐	☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (mark one on each line)

		Yes	No
6.	Accomplished less than you would like	☐	☐
7.	Did not do work or other activities as carefully as usual.	☐	☐

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (mark one response)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Chart: **30**

SF-12 (version 1) Health Survey (continued)

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks …….
(mark one on each line)

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9.	Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
10.	Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
11.	Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? (mark one response)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

Patient Signature _____ Date: _____

******Please ensure that all items have been completed!******

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Name: **D, H**
Chart: **30**
Date: **1/23/2019**

FRANK P. CAMMISA, JR., M.D., F.A.C.S.
ANDREW A. SAMA, M.D.
ALEX P. HUGHES, M.D.

SPINAL SURGERY
THE HOSPITAL FOR SPECIAL SURGERY
EAST RIVER PROFESSIONAL BUILDING
523 EAST 72ND STREET, NEW YORK, NY 10021
Telephone: 212-606-1946

Pharmacy Information:

Name of Pharmacy:

Address:

Telephone:

Please note this will be scanned in your chart for any prescription(s) requested by your doctor.

Name: **D, H**
Chart: **30**
Date: **1/23/2019**

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HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION FORM
HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)	PREFERRED NAME	DATE OF BIRTH	SOC. SEC. NUMBER

SEX ASSIGNED AT BIRTH	SEX LISTED WITH HEALTH INSURANCE	WHAT IS YOUR GENDER IDENTITY?	PREFERRED PRONOUNS
☐ FEMALE ☐ MALE ☐ INTERSEX	☐ FEMALE ☐ MALE	☐ SAMES AS SEX LISTED WITH INSURANCE ☐ OTHER: _____	☐ She/Her ☐ Ze/Hir ☐ He/His/Him

PERMANENT STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTRY	HOME PHONE	CELL PHONE	E-MAIL ADDRESS ☐ MYCHART ☐ DISCHARGE INSTRUCTIONS ☐ DECLINE

TEMPORARY ADDRESS (IF APPLICABLE)	CITY	STATE	ZIP CODE

GENERAL INFORMATION

HISPANIC ETHNICITY?	RACE	ADDITIONAL RACE	ETHNICITY
☐ YES ☐ NO ☐ UNKNOWN ☐ DECLINE			

FURHTER DESCRIPTION OF ETHNICITY # 1	FURHTER DESCRIPTION OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH
		☐ VERY WELL ☐ WELL ☐ NOT WELL ☐ NOT AT ALL ☐ DECLINED ☐ UNAVAILABLE

WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?	IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?

WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? ☐ YES ☐ NO	RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ☐ YES ☐ NO

MARITAL STATUS	VISUALLY IMPAIRED? ☐ YES ☐ NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFIY PCP OF ADMISSION? ☐ YES ☐ NO	NOTIFIY PCP OF RESULTS? ☐ ALL ☐ ABNORMAL ☐ NONE
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		

PATIENT'S EMPLOYER	PATIENT OCCUPATION	☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT	RETIREMENT DATE

EMPLOYER ADDRESS (no., street, city, state, zip code)	EMPLOYER PHONE

EMERGENCY CONTACT

FULL NAME CONTACT #1	ADDRESS (no., street, apt#, city, state, zip code)

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ☐ YES ☐ NO	SUPPORT PERSON? ☐ YES ☐ NO

FULL NAME CONTACT #2	ADDRESS (no., street, apt#, city, state, zip code)

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ☐ YES ☐ NO	SUPPORT PERSON? ☐ YES ☐ NO

PHARMACY INFORMATION

NAME:

ADDRESS:

PHONE NUMBER: **FAX NUMBER:**

Name: **D, H**
Chart: **30**
Date: **1/23/2019**

30-1

HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION DOWNTIME FORM
HOSPITAL FOR SPECIAL SURGERY

GUARANTOR (The person responsible for the bill)

GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE
EMPLOYER		OCCUPATION	☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT		RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY? ☐ YES ☐ NO	INJURED BODY PART: ☐ RIGHT ☐ LEFT	HOW DID YOUR INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		

POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)	CASE NUMBER

SECONDARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

TERTIARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

WORKERS' COMPENSATION/NO FAULT INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		

POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)	CASE NUMBER