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:

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.

PLEASE NOTE: X-Rays left at the office and X-rays taken at The Hospital for Special Surgery are stored together at the hospital (600- 1135). 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:

SpineCare Of NY
Hospital For Special Surgery

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

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 **Drs. Cammisa, Dr. Sama and Dr. Hughes** 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

Name:
Chart:
Date:

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.):

_____

_____

_____

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

_____

_____

Surgeons or other doctors seen for this condition (please specify surgeon, neurologist, pain management, etc.):

_____

_____

_____

Name:
Chart:
Date:

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 (please only include studies within the past 2 years): (X-rays, MRI, CT, Myelogram, Discogram, EMG, Bone Scan)

_____

_____

_____

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

1) 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

2) What makes your symptoms worse?

_____

3) What makes your symptoms better?

_____

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):
If more than one disorder is listed and separated by a "/" (please circle specific issue)
"If yes, please specify if available"

_____Heart Attack/Heart Failure
_____Seizure
_____Stroke
_____Asthma
_____COPD
_____Pneumonia, year____
_____High Blood Pressure
_____High Cholesterol
_____Acid Reflux/GERD
_____Tuberculosis
_____HIV/AIDS
_____Gout
_____Fibromyalgia
_____Complex regional pain syndrome (reflex sympathetic dystrophy)
_____Peripheral Vascular Disease
_____Thyroid/Parathyroid Issues
_____Anemia
_____Anxiety/Depression
_____Glaucoma/Cataracts
_____Migraines/Headaches

_____Diabetes
- Type 1 or Type 2 (please circle)
- Last AIC:

_____Stomach/Intestinal Disease Problems
_____Osteoporosis/Osteopenia
- Last DXA:
- Treatment (include year started and duration of treatment):

_____Autoimmune Disease
- Type:

_____Hepatitis/Liver Disease
_____Heart murmur/Irregular Heart Beat
_____Kidney Problems
_____Urinary Problems

_____Cancer
- Type:
- Radiation Y/N
- Chemotherapy Y/N

_____Clotting/Bleeding Disorder
- Type:
- History of blood clot Y/N

_____Psychiatric Care
- Have you ever been hospitalized Y/N

_____Drug or Opioid Addiction
- Requiring detox or rehab Y/N____

_____Sleep Apnea
- Use of CPAP or other device Y/N

_____Prolonged Steroid Use (oral, inhaler, injections)
- Indication for use:

_____Surgical Complications (including issues with anesthesia, intubation, blood transfusion, infection, nausea/vomiting)

_____Other: _____

_____

_____

_____

PREVIOUS SURGERIES (Please include date)

_____

_____

_____

_____

Have you been taking opioids for 6 months or more? Yes/No

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.			

(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 (please specify is physical): _____

Recreational Activities/Hobbies (especially those limited by pain): _____

Please check the following:
_____ Never Smoked _____ Current smoker _____ Former Smoker If former, Quit (Date:_____)

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

How many years have you smoked in total? _____

Are you willing to quit smoking if surgery is indicated ___ Yes ___ No

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)

Recreational drug use? If yes what drug_____? How often_____?

FAMILY HISTORY
Have any immediate family members been diagnosed with the following conditions (Please **specify** type):

	Yes	**No**	**Relationship**	**Type**
Spinal Disorders	_____	_____	_____	
Muscle/Nerve Disorders	_____	_____	_____	
Autoimmune Disease	_____	_____	_____	
Cancer	_____	_____	_____	
Other	_____	_____	_____	

Name:
Chart:
Date:

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

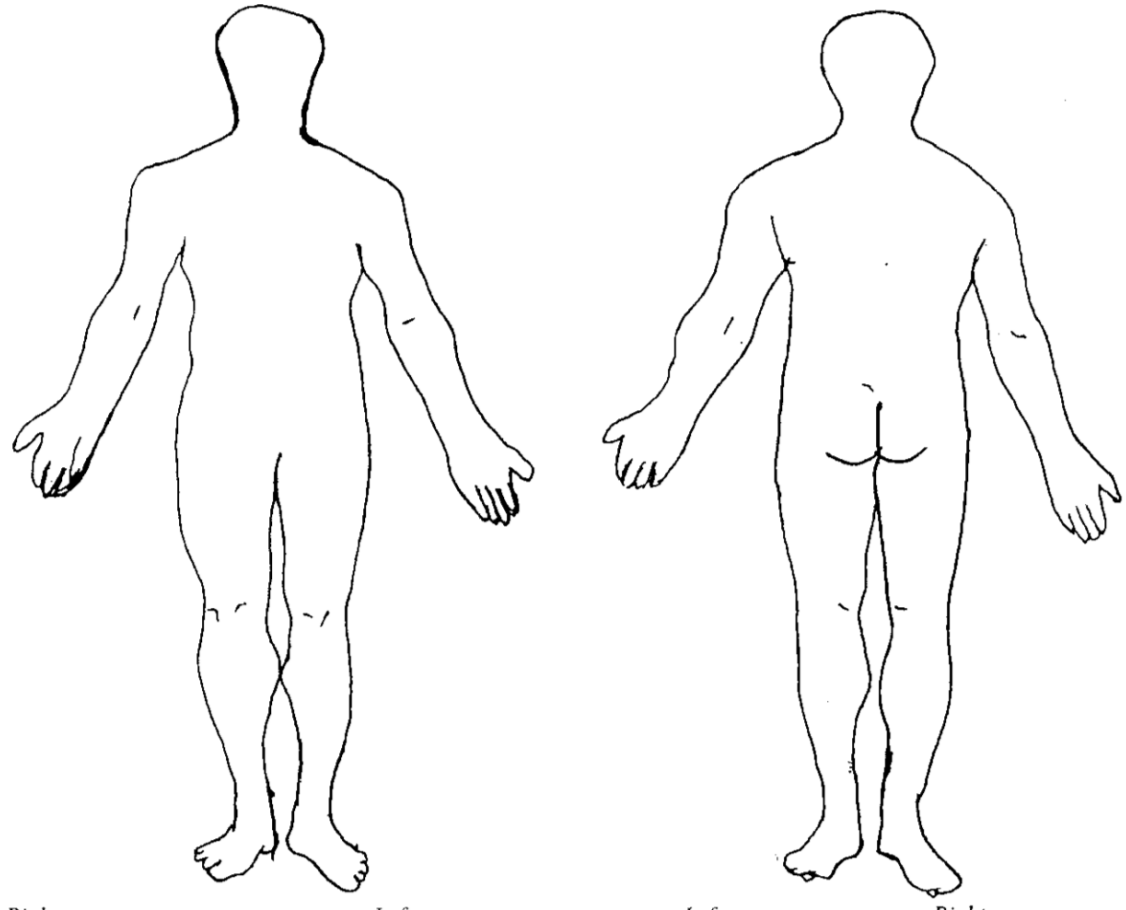
Chart:

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
>>>>	= = = =	I I I I I I I	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.

CHIEF COMPLAINT

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

EXAMINATION **Init:** _____

Date dict: _____

	Neck *Right*	**Neck** *Left*	**Back** *Right*	**Back** *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:

SF-12 (version 1) Health Survey

Patient Name: _____ Date: _____ Chart#: _____

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 <u>your health now limit you</u> 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.	<u>Moderate activities</u> such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	☐	☐	☐
3.	Climbing <u>several</u> flights of stairs.	☐	☐	☐

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

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

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

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

8. During the <u>past 4 weeks,</u> how much did <u>pain</u> 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:

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?	☐	☐	☐	☐	☐	☐

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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!******

Formatted 2009

Name:
Chart:
Date:

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Pharmacy Information:

Name of Pharmacy:

Address:

Telephone:

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