

Chart:

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**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, 3<sup>rd</sup> 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.**

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If Minor - Names of Parents: \_\_\_\_\_

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

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Compensation Case? \_\_\_\_\_ Auto Accident? \_\_\_\_\_ Registration State \_\_\_\_\_

Comp or Auto Insurance Carrier (Address and Telephone): \_\_\_\_\_

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**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:



\* 1 1 2 7 1 5 0 - 2 0 \*

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

Date: \_\_\_\_\_

Age: \_\_\_\_\_

Please check one:  Left hand dominant       Right hand dominant       Ambidextrous

Accompanied by:  Myself       With (list name & relation to patient): \_\_\_\_\_

List your primary symptoms in order of importance:

(ie low back pain, neck pain, arm/leg pain, arm/leg weakness, sensation changes, imbalance, etc)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Please check if you have any of the following symptoms (if applicable, list body part affected):

Weakness: \_\_\_\_\_

Numbness: \_\_\_\_\_

Pins & Needles: \_\_\_\_\_

Balance Impairment

Gait disturbance

Postural Changes

Bowel Dysfunction

Bladder Dysfunction

**How** and **When** did your symptoms start? (Please describe any trauma/injury, motor vehicle accident, gradual, etc)

\_\_\_\_\_  
\_\_\_\_\_

List name and specialty of other physicians seen for your symptoms (surgeons, neurologists, etc—ie Dr. Jon Doe-pain management):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any history of spine problems prior to current issue?     Yes     No

If Yes,     Lumbar     Cervical     Thoracic

Any history of previous spinal surgery?     Yes     No

If Yes, please include: date, type of surgery, and name of surgeon

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name:

Chart:

Date:



\* 1 1 2 7 1 5 0 - 2 0 \*

Which treatments have you tried? (Please include number of sessions and/or dates of treatment)

Epidural Steroid Injections: \_\_\_\_\_

Facet Injections: \_\_\_\_\_

Trigger Point Injections: \_\_\_\_\_

Physical Therapy: \_\_\_\_\_

Chiropractic Care: \_\_\_\_\_

Acupuncture: \_\_\_\_\_

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

Other Treatments: \_\_\_\_\_

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 severe:

\_\_\_\_\_ 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?  Yes  No

Are symptoms worse at a particular time of day?

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/Heart Failure
- Heart Murmur/Irregular Heart Beat
- Peripheral Vascular Disease
- Anemia
- Clotting/Bleeding Disorder
- High Blood Pressure
- High Cholesterol
- Seizure
- Stroke/TIA
- Asthma
- COPD/Emphysema
- Other: \_\_\_\_\_
- Sleep Apnea
- Acid Reflux/GERD
- Stomach/Intestinal Disease
- Hepatitis/Liver Disease
- Kidney Problems
- Urinary Problems
- Diabetes
- Thyroid/Parathyroid Issues
- Osteoporosis/Osteopenia
- Autoimmune Disease
- Gout
- Fibromyalgia
- Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)
- Glaucoma/Cataracts
- Migraines/Headaches
- Pneumonia
- Tuberculosis
- HIV/AIDS
- Anxiety/Depression
- Substance Abuse (ie opioid)
- Surgical Complications or Infections
- Cancer

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

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

*(If more medications, please attach separate medication list)*

Have you been taking opioids for 3 months or more?  Yes  No

Name:

Chart:

Date:



\* 1 1 2 7 1 5 0 - 2 0 \*

**PREVIOUS SURGERIES** (include dates)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATION ALLERGIES** (list medication and reaction)

\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Marital Status:  Single  Married  Divorced  Widowed

Occupation: \_\_\_\_\_

Recreational Activities/Hobbies: \_\_\_\_\_

Smoking Status:  Never Smoked  Current Smoker  Former Smoker

If current or prior smoking history, how many packs per day? \_\_\_\_\_

How many years have you smoked in total? \_\_\_\_\_

How many alcoholic beverages do you consume a week? \_\_\_\_\_ If former, quit date: \_\_\_\_\_  
(1 drink = 12 oz beer, 5 oz of wine, 1.5 oz hard liquor)

Recreational drug use?  Yes  No  If yes, list drug(s): \_\_\_\_\_

**FAMILY HISTORY**

Do you have a family history of any of the following conditions?

	Yes	No	Type:	Relationship
Spinal Disorders	<input type="checkbox"/>	<input type="checkbox"/>		
Muscle/Nerve Disorders	<input type="checkbox"/>	<input type="checkbox"/>		
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		

Name:  
Chart:  
Date:



\* 1 1 2 7 1 5 0 - 2 0 \*

**REVIEW OF SYSTEMS**

General \_\_\_\_\_

Skin \_\_\_\_\_

Neurological \_\_\_\_\_

HEENT \_\_\_\_\_

Cardiovascular \_\_\_\_\_

Pulmonary \_\_\_\_\_

Gastrointestinal \_\_\_\_\_

Urinary \_\_\_\_\_

Renal \_\_\_\_\_

Hepatic \_\_\_\_\_

Other \_\_\_\_\_

**PHYSICAL EXAM VITAL SIGNS:**

<b>BP</b>	<b>HR</b>	<b>RR</b>	<b>Temp</b>	<b>Height</b>	<b>Weight</b>
<b>BMI</b>	<b>O2 SAT</b>				

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:

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

<b>CHIEF COMPLAINT</b>		<b>EXAMINATION</b>		Init: _____
				Date dict: _____
<b>Neck</b>	<b>Back</b>	<b>Neck</b>	<b>Back</b>	
		<i>Right</i>	<i>Left</i>	<i>Right</i> <i>Left</i>
Pain				
Loc				<b>Reflexes</b>
Numb		B _____	_____	_____
P/N		T _____	_____	_____
Weak		BR _____	_____	_____
B/B Sx		Hof _____	_____	_____
B/Gait		IRR _____	_____	_____
Lher				<b>Sensation</b>
Spur		C5 _____	_____	_____
Abd		C6 _____	_____	_____
Val		C7 _____	_____	_____
NP		C8 _____	_____	_____
Pos		T1 _____	_____	_____
Walk		TR _____	_____	_____
Stand				<b>Power</b>
Sit		D _____	_____	_____
Sup		B _____	_____	_____
Prone		WE _____	_____	_____
Drive		T _____	_____	_____
Sleep		WF _____	_____	_____
Work		FE _____	_____	_____
Rec		GR _____	_____	_____
		Fab _____	_____	_____
				_____
		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

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DX:	Tests:	X-Rays _____
		Bonescan _____
		CT _____
RX:    Surgical		MRI _____
		Myelogram _____
		EMG _____
Conservative:		Discogram _____
		Other _____

Chart: \_\_\_\_\_

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### 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.**

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

Excellent     Very Good     Good     Fair     Poor

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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. <u>Moderate activities</u> such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Climbing <u>several</u> flights of stairs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

---

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	<input type="checkbox"/>	<input type="checkbox"/>
5. Were limited in the <u>kind</u> of work or other activities.	<input type="checkbox"/>	<input type="checkbox"/>

---

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. <u>Accomplished less</u> than you would like	<input type="checkbox"/>	<input type="checkbox"/>
7. Did not do work or other activities <u>as carefully as usual</u> .	<input type="checkbox"/>	<input type="checkbox"/>

---

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:

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**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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

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

Name:

Chart:

Date:

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SPINAL SURGERY

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.