Our staff is dedicated to providing you with quality healthcare. In order to minimize your wait at the doctor’s office, we ask that you please read and fill out the enclosed forms and bring them with you at the time of your initial visit. Please answer all questions that apply to you.

Our staff recommends that patients arrive 30 minutes before their scheduled appointment time in order to be registered in a timely manner. If any questions or problems arise, please do not hesitate to call during our regular business hours, which are 9:00 am to 5pm Monday through Thursday and 9:00 am to 4:30pm on Friday.

Thank you.

Steven K Jacobs, MD, PHD.

REMINDER:

PLEASE BRING ANY RECENT FILMS AND REPORTS PERTAINING TO YOUR NECK AND/OR BACK WITH YOU AT YOUR TIME OF VISIT. FAILURE TO DO SO WILL RESULT IN THE RESCHEDULING OF YOUR APPOINTMENT AS THE DOCTOR NEEDS THESE ITEMS IN ORDER TO PROVIDE YOU WITH A COMPREHENSIVE EVALUATION. IN ORDER FOR THE DOCTOR TO EVALUATE YOUR DEGREE OF PAIN, PLEASE DO NOT TAKE ANY PAIN MEDICATION, PRESCRIBED AND/OR OVER THE COUNTER, 2 HOURS BEFORE YOUR VISIT. IF YOU CANNOT MAKE YOUR APPOINTMENT PLEASE GIVE THE OFFICE 24 HOURS NOTICE.

WHAT TO BRING TO YOUR VISIT:

- MRI FILMS & REPORTS
- XRAY FILMS & REPORTS
- EMG REPORTS
- CAT SCAN FILMS & REPORTS
- DISCOGRAM FILMS & REPORTS
- PHYSICAL THERAPY REPORTS
- INSURANCE CARD
- COPAY (IF NEEDED)
- REFERRAL (IF NEEDED)
- PHOTO ID
PATIENT REGISTRATION INFORMATION
Steven K. Jacobs M.D., Ph.D.
New York Neurosurgical, PLLC

PLEASE PRINT AND COMPLETE ALL SECTIONS BELOW

**PATIENT INFORMATION**

Name: __________________________________ Date of Birth: __________ Age: __________

Address: __________________________________

________________________________________

Marital status: Single Married Divorced Widowed

________________________________________

Social Security #: _________________________

(Optional) Ethnicity: __________ (Optional) Language: __________ (Optional) Race: __________

Home #: __________________ Work #: __________ Cell #: __________

Emergency Contact/ Relationship: ______________________________ Phone: __________

Are you currently working? Yes No Employer/ Name of school: __________________________

Occupation: __________________________ Job Duties: __________________________

**PRIVATE INSURANCE INFORMATION**

Primary Insurance: __________________________

Member ID: __________________________

Group #: __________________________

Name of Insured: __________________________

Relationship to Insured: __________________________

Employers Name: __________________________

Phone#: __________________________

Secondary Insurance: __________________________

Member ID: __________________________

Group #: __________________________

Name of Insured: __________________________

Relationship to Insured: __________________________

Employers Name: __________________________

Phone#: __________________________
WORKERS COMPENSATION

Is this a work related injury? Yes No
Insurance Carrier: ___________________________ Are you currently working? Yes No
Insurance Address: ___________________________ Responsible Employer: ___________________________
_________________________ Employer Address: ___________________________
Case #: ___________________________ Employer Phone #: ___________________________
WCB #: ___________________________ Job Title (when injured): ___________________________
Date of Accident: ___________________________ Job Duties (when injured): ___________________________

Describe how the present injury occurred: ____________________________________________________
Have you had any prior treatment for this injury? Yes No If yes please explain: ___________________________

NO- FAULT (AUTO ACCIDENT)

Is this a motor vehicle related injury? Yes No
No Fault Carrier: ___________________________ Date of Accident: ___________________________
Carrier Address: ___________________________ Claim Representative: ___________________________
Claim#: ___________________________ Phone #: ___________________________

If this is or has ever been a worker’s compensation or no fault claim and the information is not provided, the patients will be responsible for all denials and balances.

PATIENT REFERRAL INFORMATION

Who referred you to our office: ___________________________ Phone #: ___________________________
Primary Care Physician: ___________________________ Phone #: ___________________________
Attorney: ___________________________ Phone #: ___________________________

Signature: ___________________________ Date: ___________________________
PATIENT HEALTH HISTORY QUESTIONNAIRE
Steven K. Jacobs M.D., Ph.D.
New York Neurosurgical, PLLC

Chief Complaint: ____________________________________________________________

List any medical problems that run in your family (heart disease, high blood pressure, diabetes etc):
_________________________________________________________________________
_________________________________________________________________________

SOCIAL HISTORY
Do you smoke: Yes No Do you drink: Yes No
If yes how much/ how often: ____________ If yes how much/ how often: ____________

Do you have any tattoos: Yes No Do you have any piercings: Yes No
If yes, where: ________________________ If yes, where: ________________________
L or R handed? Height: _______ Weight: _______ BMI: _______

PAST SURGICAL HISTORY
Please list any surgeries or major illnesses you have had in the past:
Surgery/ Hospital: __________________________________________ Year: ____________
Any Complications: __________________________________________

Surgery/ Hospital: __________________________________________ Year: ____________
Any Complications: __________________________________________

Surgery/ Hospital: __________________________________________ Year: ____________
Any Complications: __________________________________________

ALLERGIES/ MISCELLANEOUS
Pacemaker: Yes No
Latex Allergy: Yes No
List any allergies to medication or metals:
Anesthetic Complications: Yes No
Do you have any metal in your body: Yes No
## CURRENT MEDICATIONS

Please list any medications you are currently taking:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
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## CURRENT MEDICAL CONDITIONS

Please check if you currently have or had any problems with:

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Yes</th>
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<tbody>
<tr>
<td><strong>Constitutional:</strong></td>
<td></td>
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<tr>
<td>Fever</td>
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<tr>
<td>Weight Loss</td>
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<tr>
<td><strong>Eyes:</strong></td>
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<tr>
<td>Glaucoma</td>
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<td></td>
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<tr>
<td>Cataracts</td>
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<tr>
<td>Date of last exam</td>
<td></td>
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<tr>
<td><strong>ENT:</strong></td>
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<tr>
<td>Hearing Loss</td>
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<tr>
<td>Ringing L or R</td>
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<tr>
<td>Balance Problem</td>
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<tr>
<td><strong>Sinus Problems/ Headaches</strong></td>
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<tr>
<td><strong>Cardiovascular:</strong></td>
<td></td>
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<tr>
<td>High BP</td>
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<tr>
<td>High Cholesterol</td>
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<tr>
<td>Chest Pain/ Angina</td>
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<tr>
<td>Date of Last EKG</td>
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<tr>
<td><strong>Respiratory:</strong></td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Chronic Cough</td>
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<tr>
<td>Shortness of breath</td>
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<tr>
<td><strong>Gastrointestinal:</strong></td>
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<tr>
<td>Nausea/Vomiting</td>
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<td>Indigestion or pain when eating</td>
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<tr>
<td><strong>Genitourinary:</strong></td>
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<tr>
<td>Urinary Tract Infection</td>
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<tr>
<td>Difficulty starting or stopping stream</td>
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<tr>
<td>Renal/ Kidney Problems</td>
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<td><strong>Endocrine:</strong></td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Increased Appetite</td>
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<td><strong>Hematological/Lymphatic:</strong></td>
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<tr>
<td>Anemia</td>
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<td>Hemophilia</td>
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<td><strong>Psychiatric:</strong></td>
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<tr>
<td>Anxiety</td>
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<td>Depression</td>
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<td><strong>Musculoskeletal:</strong></td>
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<tr>
<td>Back Pain</td>
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<td>Arthritis</td>
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<tr>
<td><strong>Other:</strong></td>
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<td>Neck Pain</td>
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The above information is true to the best of my knowledge:

Signature: _______________________________

Date: _______________
PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

The numbers you have provided us with will be used to contact you.

Y  N

May we speak to other members of your household

If no, please specify who we can’t speak to ______________________

Can we leave detailed messages at your

Home Phone Number ____  ____
Cell Phone Number ____  ____
Work Phone Number ____  ____

(If NO is selected we will not leave a detailed message, instead we will leave contact information for you to reach us at)

Signature: __________________________________________  Date: ______________________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information (Please fill out this section if you wish a specific person to be able to obtain your medical information).

Please list any persons who can obtain your medical records, such as a primary care doctor

<table>
<thead>
<tr>
<th>Name of Person/Facility:</th>
<th>Address:</th>
<th>Phone #:</th>
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Signature: __________________________  Date: ______________________
NEW YORK NEUROSURGICAL
4 Lafayette Court
Fishkill NY 12524
390 Crystal Run Road, Middletown NY 10940
Steven Jacobs, MD

NO-SHOW CONSENT
Your copay is due at the time of your visit. If you do not have it we will charge you an administrative handling fee of $20.00. Also since we reserve a certain amount of time for each appointment it is important that if you need to reschedule you give us 24 hours notice. If not we enforce a $25.00 no show fee for Dr. Jacobs and a $50.00 charge for Dr. Rosenblatt. By signing below you are agreeing to the terms of this agreement. Failure to sign may result in scheduling privileges.

Patient Signature: ___________________________ Date: _______________
INSURANCE AUTHORIZATION

I request that payment of authorized Medicare Benefits and or my insurance company be made on my behalf to New York Neurosurgical, PLLC for any services furnished to me by this group. I authorized any holder of medical information about me to release to the insurance companies and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. I know that I am responsible for any balance not covered by my insurance.

Signature: ___________________________________ Date: __________________________

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits be made directly to New York Neurosurgical, PLLC, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney’s fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: ________________________________ Date: ______________________________

DIRECTIONS:

FROM THE NEWBURGH, NEW WINDSOR AREA:

- Take route I-84 East
- Go across Newburgh-Beacon bridge
- Take exit 13 for RTE 9 N
- When you get off the exit make a left at the light onto Route 9 going North
- Make right turn on to Route 52 going East
- Bear left at fork in road on to Route 82 at light
- Make right on Lafayette Court. Make Right and we are 2nd building on right.

FROM POUGHKEEPSIE:

- Take Route 9 South towards Fishkill
- You will go through Wappingers Falls and into Fishkill.
- Make a left on to Route 52 going East
- Bear left at fork in road on to Route 82 at light
- Make right on Lafayette Court. Make Right and we are 2nd building on right.

From Connecticut

Take 84 W to exit 13 North Fishkill
Merge on to Route 9 going North
Make right turn on to Route 52 going East
Bear left at fork in road on to Route 82 at light
Make right on Lafayette Court. Make Right and we are 2nd building on right.