Altus Neurosurgery & Spine, PLLC

Patrick B. Senatus, M.D., Ph.D.

Name _____Male / Female Status: S M W D P Today's Date_____
Street Address_____ DOB _____/_____/_____
Town_____ ST_____ ZIP_____ Phone ( ) _____ Cell ( ) _____
SSN _____/_____/_____ Driver's License #_____ Parent's Name if Child_____
Email Address_____ Emergency Contact_____ Phone ( ) _____
Employer (parent's if patient is child) _____ Work Phone ( ) _____
Preferred Pharmacy_____ Located in _____ Pharmacy Phone ( ) _____
Primary Care Physician_____ Who referred you to our office? _____

Is this a (please circle) **Worker's Compensation Case, Auto Accident or Personal Injury?** Date of Injury __/__/___
**A separate form will be needed to complete this information. Please ask the receptionist
Do you have an attorney representing you? Y/N State where injury occurred? ____
Attorney Name_____ Phone #_____
Attorney address_____

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Attorney Name_____ Phone #_____
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Insurance Information **PLEASE COMPLETE EVEN IF THIS IS DUE TO WORKER'S COMP/AUTO/ PERSONAL INJURY

Primary	**Secondary**
Ins. Co._____	Ins. Co._____
Policy Holder's ID#_____	Policy Holder's ID#_____
Group #_____	Group #_____
Subscribers Name_____	Subscriber's Name_____
Subscribers SSN_____	Subscribers SSN_____
Subscribers DOB ___/___/_____	Subscribers DOB ___/___/_____

Subscriber is (please circle one): Self Spouse Parent Partner Other_____

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Subscribers DOB ___/___/_____	Subscribers DOB ___/___/_____

Subscriber is (please circle one): Self Spouse Parent Partner Other_____

I have been notified of HIPAA Privacy Practices. A copy of the practice Privacy Practices may be found in our waiting room for review.
I have authorized the practice to speak to the following person(s) regarding my healthcare_____

You may call my home and leave a message on an answering machine or person who answers the phone: Y / N
You may call my work and leave a call back number: Y / N You may fax to #_____
I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to the practice for services rendered. I understand that even though I have insurance coverage, I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Today's Date _____ Patient of Authorized Signature_____

Name: _____ Date_____/_____/_____

Date of Birth _____/_____/_____ Age: _____ Gender: Male____ Female____

Present Problem

Where is your discomfort or the reason for your visit?
How long have you had the discomfort?
What caused the problem?
What makes your symptoms worse?
Do you have weakness? If so, where?
Do you have numbness? If so, where?
What treatments have you had? Physical Therapy Injections Medications Mod Activity/Rest
Is this a work related injury?
Is there a lawsuit regarding the injury?

Past Medical History: Do you currently have or have you ever been treated for any of the following medical conditions? **Please circle the specific condition if there is more than one listed**.

Condition	Yes	No	Condition	Yes	No
Asthma			Ulcers/Acid Reflux/GERD		
Tuberculosis			Osteoporosis/ Osteopenia		
COPD			Hypo/ Hyperthyroid		
Heart disease/ Pacemaker			Diabetes mellitus Type I/ Type II		
Heart Attack/ Angina			Renal Failure/ Kidney Disease		
High Blood Pressure			Hepatitis/Liver Disease Cirrhosis		
High Cholesterol			Cancer:		
Peripheral Vascular Disease			Sexually Transmitted Disease		
Anemia			HIV/AIDS		
Blood Transfusion			Medication Dependency		

Pre-Established Specialists: Please indicate if you have ever seen or are currently treating with one of the below specialists and list the name of the physician.

Cardiologist:	Pain Management:	Pulmonologist:

Hematologist:	Endocrinologist:	Gastrointestinologist:
Gynecologist:	Hepatologist(liver):	Immunologist:
Neurologist:	Neurosurgeon:	Oncologist:
Orthopedist:	Rheumatologist:	Other:

List ALL medications or supplements:

Drug	Dosage	Drug	Dosage

Allergies

Please list any allergies that you have to food, medications, or material such as latex…

_____

_____

_____

Name_____ Date_____/____/_____

Past Surgical History: Please list any previous hospitalizations or surgeries you have had, dates & surgeon.

Social History

Height_____ Weight_____

Are you currently employed? _____ Yes _____No

Occupation_____

Exercise Level? ___ No Exercise ___ 1-2 Times a Week ___ 3+ Times a Week

Do you use tobacco? ____Yes ____No _____Quit – how long ago? _____

Tobacco Product: ____ Cigarette ____Smokeless Tobacco ____Cigars ____ other

Average you smoke per day? ____1/2 pack ____1 pack ____1 ½ packs ____ other

Do you drink Alcohol? Yes / No # of days per week_____ # drinks per week _____

Review of Systems

Do you experience any of the following? (Check all that apply)

___ Weight loss/gain	___ Fatigue/weakness	___Fever/chills
___Night Sweats	___Migraine headaches	___Visual changes
___Glasses/contact lenses	___Hearing loss	___Vertigo
___Nausea/vomiting	___Tinnitus/ringing in ears	___Nosebleeds
___Bleeding Gums	___Dental pain/cavities	___Hoarseness
___Sore throat	___Shortness of breath	___Cough
___Wheezing	___Coughing of blood	___Angina/chest pain

___Heart murmur ___Pacemaker ___Heartburn/reflux
___Diarrhea/constipation ___Abdominal pain ___Jaundice
___Bloody stool ___Frequent Urination ___Pain with urination
___Kidney Stones ___Blood clots/DVT/PE ___Varicose veins
___Easy Bruising/bleeding ___Memory loss ___Seizures
___Paralysis ___Depression/anxiety ___Seasonal allergies

FAMILY HISTORY

Indicate family members who have been diagnosed with any of the following:

	Father	Mother	Brother	Sister	
Lung Disease	_____	_____		_____	_____
Problem with Anesthesia	_____	_____		_____	_____
Cancer	_____	_____		_____	_____
Leukemia	_____	_____	_____	_____	
Heart Disease	_____	_____	_____	_____	
High Blood Pressure	_____	_____	_____	_____	
Arthritis	_____	_____	_____	_____	
Stroke	_____	_____	_____	_____	
Diabetes	_____	_____	_____	_____	

Patrick B. Senatus M.D., Ph.D., F.A.C.S.

ASSIGNMENT, RELEASE OF INFORMATION, PATIENT RESPONSIBILITES AND HIPPA FORM

Name: _____ Today's Date: ____/____/_____

Assignment of Benefits: I herby authorize and direct my insurance carrier(s), to issue payment check(s) directly to Patrick B. Senatus, M.D., Ph.D. for medical services rendered to me regardless of my insurance benefits. I understand that I am financially responsible for any amount not covered by insurance.

General patient responsibilites: Patient acknowledges, in certain circumstances, insurance companys may send a check for services provided by Patrick B. Senatus directly to the patient. If the above occues the patient shall immediately contact our billing department to get instructions on how to remit payment. The patient acknowledges, they remain responsible for the full amount of the above-mentioned check plus any resonable cost, co-payments or co-insurance associated with the colectin of said funds until it is received by the treating physician.

HIPPA PRIVACY PRACTICES: With my consent, Dr. Patrick B. Senatus and the office staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Senatus and his office reserve the right to revise our Notice of Privacy at anytime. A revised notice of Privacy Practices may be obtained by verbal request to the Privacy Office at 112 East 61st Street, New York, New York.With my consent, Dr. Senatus and staff may mail to my home or other designated locations, items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are sealed. With my consent, the office staff may call my home for appointment reminders and abnormal test results. I have the right to request that the practice restrict how it uses or discloses my protected Health Information or carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting that they practice be able to use and disclose my protected Health Information. I may revoke my consent in writing accept to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

Today's Date:____/____/_____Patient or Authorized
Signature:_____

PAYMENT POLICY

Workers compensation, auto accident and personal injury cases MUST also sign our payments policy

If I do not have insurance, an initial payment of $350.00 will be required for your first visit. This amount is a partial payment only. There may be additional services that may include a brace, injections, etc., which would be an additional cost. All co-payments must be paid upon checking in with the receptionist. If you do not have your co-payment, your appointment will be rescheduled. If you

insurance requires a referral, it is your responsibility to obtain that referral to see our providers. If a referral is not received by our office prior to your scheduled appointment, you will be responsible for full payment for the visit or your visit may be rescheduled.You are responsible to pay any balances due to Dr. Senatus within 30 days after your insurance has paid their portion. If payment is not received, our office reserves the right to turn your account over to a collection agency. All check returned for non-sufficient funds will be subject to an additional returned check fee. I have read and understand the above payment policy.

Today's Date____/____/_____ Patient or Authorized Signature_____