NeuroCare
LONG ISLAND
Member of **Northwell Health Physician Partners®**

INITIAL VISIT INFORMATION DATE: _________________

NAME: ____ DOB: ________________ AGE: ___________

REASON FOR VISIT (*Please be specific)*

____

____

Have you completed Physical Therapy for this condition? ( ) YES ( ) NO If yes, # of weeks: ___ Facility: ___________
Have you completed Pain Management Treatment for this condition? ( ) YES ( ) NO
If YES, Injections? ________________________ Medication? ________________________________
Have you seen or are you seeing a chiropractor? YES or NO If yes, name: _______________________________

MEDICAL HISTORY
Select and list relevant medical conditions:
( ) Arthritis ( ) Epilepsy
( ) Asthma ( ) Heart Disease
( ) Bleeding Disorders ( ) Hepatitis
( ) Cancer ( ) High Blood Pressure
( ) Diabetes ( ) Kidney Disease
( ) Emphysema ( ) Neurologic Disorder
( ) Pacemaker ( ) Stents
( ) ______________________________________

MEDICATIONS

List all medications you are taking:

____
____
____
____
____
____

FAMILY HISTORY
Select and list all that apply:
( ) Asthma ( ) High Blood Pressure
( ) Cancer ( ) Kidney Disease
( ) Diabetes ( ) Strokes
( ) Heart Disease
( ) ____

SURGICAL HISTORY

List all surgeries you have undergone with dates:

____
____
____
____
____

ALLERGIES

Medications, food, contact, environmental:

____
____
____
____
( ) Adverse reaction to CT or MRI contrast (dye)
( ) Adverse reaction of Anesthesia

RELATED HEALTH
Are you a smoker? ( ) YES ( ) NO
Do you drink alcohol regularly? ( ) YES ( ) NO
Do you use drugs? ( ) YES ( ) NO

SOCIAL HISTORY
Are you currently working? ( ) YES ( ) NO
Occupation: _______________________________
Do you have children? ( ) YES ( ) NO
Are you currently pregnant? ( ) YES ( ) NO

Please turn page over and complete reverse side.

Tell us about your symptoms

Do you have weakness in a foot or hand?

☐ Yes ☐ No

How long have you suffered from these symptoms?

☐ ≤6 weeks ☐ 7 to 12 weeks ☐ 4 months or more

or ☐ Specific Date: ____ / ____ / _____

Do you have pain radiating PAST your knee or elbow?

☐ Yes ☐ No

Does your leg or arm ever go numb?

☐ Yes ☐ No

Have you had back or neck surgery before?

☐ Yes ☐ No

Does your back or neck pain wake you up at night?

☐ Yes ☐ No

How many pills do you take each day for pain relief?

☐ no pills ☐ 1 to 4 pills ☐ 5 or more pills

How do symptoms affect your life?

Which of the following describes you currently?

☐ Working
☐ Not working due to back or neck problem
☐ Not working due to another health problem
☐ Homemaker, retired or unemployed

Did your back or neck injury happen at work?

☐ Yes ☐ No

The following are activities you might do in a day. Does your back or neck pain limit you in these activities, and if so, how much?

Lifting or carrying groceries

☐ Limited a lot ☐Limited a little ☐Not limited at all

Climbing several flights of stairs

☐ Limited a lot ☐Limited a little ☐Not limited at all

Standing for 30 minutes

☐ Limited a lot ☐Limited a little ☐Not limited at all

Your expectations

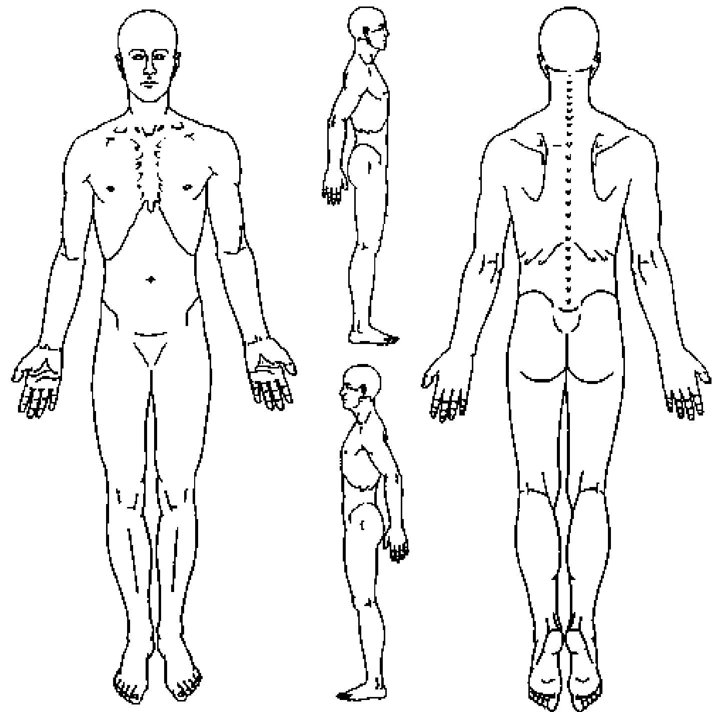
What results do you expect from your care?

Relief from pain symptoms	☐Yes	☐No	☐Doesn't apply
Return to your job	☐Yes	☐No	☐Doesn't apply
Return to leisure activities	☐Yes	☐No	☐Doesn't apply
Improved sleep	☐Yes	☐No	☐Doesn't apply

Where is your pain located?

Using the pictures, shade with a pen or pencil the parts of your body which are affected by pain.

Right ↓ Right ↓ Right ↓



Left ↑ Left ↑ Left ↑

We may have a nurse call you to follow up on your symptoms and check to see how you are doing 3 months from now. May we call you at the number you provided?

☐ Yes ☐ No

Kevin Mullins, MD ·Salvatore Zavarella, DO ·Joshua Ryan, MD, ·Salvatore Insinga, DO
·1175 Montauk Hwy, Suite 6, West Islip, NY 11795
·110 E. Main St. 2B, Huntington, NY 11743 ·4681 Veterans Memorial Highway, Holbrook, NY 11741
722 Montauk Highway, West Islip, NY 11795

Name ______________________________ Date of Birth _____/_____/_____ Age______ M / F

Address ______________________________

SS# ________-________-________ Marital Status S M W D S Email ______________________________

Preferred Contact Method | | | Message? (Y or N)
☐ Home Phone (_________) ______________________ Y N
☐ Cell Phone (_________) ______________________ Y N
☐ Work Phone (_________) ______________________ Y N
☐ Alternate Phone (_________) ______________________ Y N

How would you like to receive your Appointment Confirmations? ☐ **Text to Cell Phone** ☐ **Call to HOME or CELL (Please circle)**

I authorize my physician and the medical staff to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Contact Information

Referring Doctor Name______________________________ Telephone #______________________

Primary Care Physician ______________________________ Telephone # ______________________

Pharmacy and Location ______________________________ Telephone # ______________________

INSURANCE INFORMATION **If Change of Insurance: Effective DATE**______________________

Primary Insurance ______________________________ Member ID #______________________

Policy Holder ______________________ Policy Holder SS# ______________________ Policy Holder DOB ______________

Relationship to Patient ______________ Policy Holder Employer______________________________

Secondary Insurance ______________________________ ID # ______________ Policy Holder ______________

Policy Holder SS#______________ Policy Holder DOB ______________ Relationship to Patient ______________________

WORKERS COMPENSATION or NO FAULT <u>OR</u> THIS IS NOT RELATED TO A CAR ACCIDENT OR INJURY AT WORK ______(initial)

Insurance Carrier______________________________ Claim Number______________________________

Date of Injury/Accident______________________ Adjuster ______________________ Phone ______________________

Workers Compensation Only:

Employer ______________________ Employer Address______________________________

Job Title/Description______________________ How did injury occur______________________________

On the date of injury, what were your usual work activities: ______________________________

Attorney's Name & Phone Number ______________________________

______________________________ ______________________

Signature of Patient **Date**

Rev July 2023

I hereby authorize and direct Kevin J. Mullins, MD; Salvatore Zavarella, DO; Joshua Ryan, MD; Salvatore Insinga, DO.; (herein referred to as “the provider,”) having treated me, to release to Medicare, Medicaid, governmental agencies, insurance carriers, or others who are financially liable for medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment.

I hereby guarantee payment to the provider of all charges and fees incurred for services rendered to me. I understand that if an insurance company (non-participating) fails to pay all or part of this claim, that I am responsible, upon notice, for payment in consideration of the physician's services which have been or will be provided to the patient. I hereby assign to the provider all of the medical insurance benefits to which I may be entitled from Medicare, Medicaid, governmental agencies, insurance carriers, no-fault carriers, or others that are financially liable for my care. I hereby authorize to the provider authority to file claims for payment and appeals on determinations of those claims on my behalf.

I hereby designate, authorize, and convey to the provider, having treated me to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan
(including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy including fines.

I request that payment of authorized benefits be made on my behalf to the provider.

________________________________ ____________________

Signature of Patient **Date**

________________________________ ____________________

Signature of Person/Guarantor (Other than Patient) **Witness**

E-PRESCRIBING / MEDICATION HISTORY CONSENT:

Your doctor uses an electronic medical record system that allows electronic prescribing of medications. Prescriptions are sent to your pharmacy through a secure connection which improves the accuracy and timely transmission of your medical information, and which complies with federal regulations. E-prescribing programs must include medication history which provides your doctor with information about previous and current medications you are taking to minimize the number of adverse drug reactions. Your signature certifies that you have read and understand the scope of your consent and you authorize the access of your medication history.

________________________________ ________________________

Signature of Patient **Date**

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediates of carriers any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.

________________________________ ____________________

Signature of Insured or Authorized Representative **Date**

Acknowledgement of Receipt

ADDRESSOGRAPH

I have received a copy of the Provider's Notice of Privacy Practices.

Patient/Agent/Relative/Guardian* (Signature) Date Time Print Name Relationship if other than patient

Telephonic Interpreter's ID # Date Time)

OR

Signature: Interpreter Date Time Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature) Date Time Print Witness Name

---

PROVIDER USE ONLY

_______ Patient or patient representative refused to sign/accept Notice of Privacy Practices

_______ Patient unable to sign

Telephonic Interpreter's ID # Date Time

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

SYSHIPAA (1/29/24)