Manhattan Physical Medicine & Rehabilitation, LLP

Registration Information

DATE_____

PATIENT NAME_____
Last Name First Name Middle Initial

(M___F____) **(Single_____ Married_____)**

ADDRESS_____

CITY_____**STATE**_____**ZIP**_____

DATE OF BIRTH_____**SS#**_____

Preferred language: _____ **Race:** _____ **Ethnicity:** _____

(*Please check appropriate box to indicate where you'd like us to contact you*)
( )HOME TELEPHONE_____**Email**_____

( )WORK TELEPHONE_____ **( )CELL**_____

EMPLOYED BY_____**OCCUPATION**_____

BUSINESS ADDRESS_____

SPOUSE_____ **EMPLOYED BY**_____

PATIENT RELATIONSHIP TO PRIMARY INSURED: SELF / SPOUSE / CHILD

PATIENT'S PRIMARY INSURANCE_____**ID#**_____

SECONDARY INSURANCE_____**ID#**_____

REFERRING PHYSICIAN_____

IF NOT REFERRED, HOW DID YOU HEAR ABOUT US? _____

TO WHOM SHOULD WE SEND THE REPORT_____

Preferred Pharmacy: _____ ***Phone #*** _____

IS YOUR CONDITION RELATED TO EMPLOYMENT? YES____NO_____
IS YOUR CONDITION RELATED AUTOACCIDENT? YES____NO_____
IFYES, ATTACH WORKMENS'S COMPENSATION OR NO FAULT INFO.

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____

PHONE#_____RELATIONSHIP TO THE PATIENT_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

And assign directly to Dr. _____ all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
(Signature of Insured/Guardian) (Date)

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Dr. _____ for any services furnished me by the physician/therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration 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 claim.

If 'other health insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charges determination of the Medicare carrier as the full charge, and the patient is responsible only the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
(Beneficiary signature) (Date)

Manhattan Physical Medicine and Rehabilitation, LLP
133 East 58th Street
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New York, NY 10022
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Loren M. Fishman, M.D. LIC: 150259
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Notice of Privacy Practices for Protected Health Information

I have received and understood the copy of the Notice of Privacy Practice for Protected Health Information from the office of Manhattan Physical Medicine & Rehabilitation. I understand that this notice describes how medical information about my care and/or treatments may be used and disclosed, and how I can get access to this information.

I understand that this practice reserves the right to change the terms of this Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I changes to this policy occurs, this practice will provide me a revised Notice of Privacy Practices upon request.

_____/ _____
(Print Name) **(Date of Birth)**

_____/ _____
(Signature) **(Date)**

HISTORY:

Height: _____ Weight: _____

CHIEF COMPLAINT:

(What is the reason for your visit? _____

HISTORY OF THE PRESENT ILLNESS:

(For how long have you had this symptom or problem? When did it begin? _____

(Is the symptom or problem related to an inciting event, such as trauma, illness or other stress?

(Yes (No Explain _____

(Do you have pain? (Yes (No

(Describe the pain: (Check all that apply.) (dull ache/cramp (burning (sharp/stabbing (tingling/numbness

(Other: (Describe) _____

(Please mark the pain diagram below with an "X" to indicate the location of your pain. If the pain spreads, use arrows to indicate the direction in which the pain moves. (Example ((((.....)

Pain Diagram

(How severe is the pain? (Circle)

Scale: 1 2 3 4 5 6 7 8 9 10

Tolerable Moderate

Excruciating

(How long does the pain last?

_____

(When does the pain occur?

(In early morning upon awakening

(At night disturbing sleep

(Daytime/during work

(Other time _____

(With movement: (Positional:

(Bending (Sitting

(Lifting (Standing

(Walking (

Reclining

(Are there other symptoms associated with the pain? (Example - joint stiffness, muscle spasm)

(Yes (No Explain _____

(What makes the pain worse? _____

(What makes the pain better? _____

(Which diagnostic tests have you had for your current problem? (Check all that apply)

(X-rays (MRI (CT scan (Myelogram (Bone scan (Bone Density (Blood Test (EMG

(Other _____ (None

(Which treatments, if any, have you had for your current problem? (Check all that apply)

(Physical or occupational therapy (chiropractic therapies (acupuncture (joint injections

(Prescription and/or over-the-counter medications (herbal medications (surgery (other treatment

_____

_____

PAST MEDICAL / SURGICAL HISTORY:

(Do you have any other medical conditions or problems? (Diabetes; heart; asthma; other) (Yes (No

List: _____

_____

(List any previous surgeries and dates.

_____

_____

(List any current medications taken (with dosage and frequency if known).

_____

_____

(List any medications used in the past if taken on a long-term basis.

_____

(List any medication allergies. (Examples: hives, skin rash, breathing problems, throat swelling). (None

_____

_____

(Have you ever been treated with chemotherapy or radiation? (Yes (No

Explain _____

(Have you ever used or been prescribed steroids? (Yes (No

If so, what type? (Corticosteroids (cortisone, prednisone, etc.)

(Anabolic steroids (testosterone, as in body-building, weight-gain, etc.)

FAMILY HISTORY:

(Have any family members (including only blood-relatives) been diagnosed with any of the following illnesses?

(Heart disease _____

(High blood pressure _____

(Stroke _____

(Diabetes _____

(Nerve problem _____

(Cancer _____

(Genetic or inherited disorder _____

(Blood disease or Anemia _____

(Other _____

SOCIAL HISTORY:

(Marital status: (Single (Married (Life Partner (Separated (Divorced (Widowed

(Do you have children? (Yes _____ (No

(Smoking history: (Current smoker: # of packs per day _____ Date started smoking _____

(Ex-smoker: Date stopped smoked _____ Date started smoking _____ # of packs per day ____

(Never smoked

(Alcohol consumption: (Never (Occasionally (Frequently _____

(Any current or prior recreational drug use: (Yes, type _____ (No

FUNCTIONAL HISTORY:

(Occupation _____

(Are you currently working? (Yes (No

If no, are you: (Retired (Worker's Compensation

(Disabled (Explain) _____

(None of the above _____

(Do you require assistance in your daily activities? (Yes (No

Please check all that apply below:

Help with: (bathing, (dressing, (cooking, (cleaning, (food shopping, (laundry,

(Other _____

Help from: (family members, (home health aide, (home attendant, (visiting nurse?

(What are your Exercise/Recreational activities, if any? _____

_____

(Describe your place of residence. Please check all that apply below:

(Private house (apartment (assisted living facility

(With elevator (without elevator (with stairs / walk-up

(Do you use an assistive device for safe mobility? (Yes (No

Please check all that apply below:

(Straight cane, (quad cane, (crutches, (walker,

(Standard wheelchair, (electrically-powered wheelchair, (scooter

(Brace Which type of brace? _____

REVIEW OF SYSTEMS

Patient Name: _____ **Date**: _____

Constitutional Systems:	**Yes**	**No**
Fever / Chills	(	(
Weight loss or gain		(
Fatigue	(	(
Night sweats		(

Skin:		
Rashes or color changes	(	(
Itching or dryness		(
Hair changes		(
Nail changes		(

Eyes:		
Loss of vision / fluctuating vision	(	(
Distorted vision or haloes	(	(
Eye pain or soreness		(

Ears, Nose, Mouth, Throat		
Hearing difficulty		(
Ringing or buzzing in ears	(	(
Sinus congestion / post-nasal drip	(	(
Nosebleeds		(
Dryness/hoarseness		(

Cardiovascular:		
Chest pains		(
Palpations		(
Leg cramps with walking	(	(
Leg swelling / edema		(

Respiratory:		
Cough	(	(
Shortness of breath		(
Wheezing		(

Endocrine:		
Heat or cold intolerance	(	(
Excessive thirst or hunger	(	(

Allergy/Immunology:		
Allergies		(
Autoimmune / Collagen disease	(	(

Gastrointestinal:	**Yes**	**No**
Difficulty Swallowing	(	(
Vomiting / Nausea		(
Heartburn / Upset Stomach	(	(
Constipation		(

Genito-Urinary:		
Urinary frequency	(	(
Urinary pain or burning		(
Urinary bleeding		(
Urinary incontinence		(
Prostate symptoms		(

Obstetric/Gynecologic:		
Currently pregnant	(	(
Breast masses or discharge		(
Vaginal bleeding, discharge		(

Musculoskeletal / Rheumatological:		
Joint pain, swelling, redness	(	(
Muscle pain or cramps	(	(

Neurological:		
Headaches		(
Numbness or tingling	(	(
Weakness or paralysis		(
Tremor		(
Balance loss, dizziness / falls	(	(

Are you: (Right-handed or (Left-handed

Psychiatric:		
Anxiety		(
Depression		(
Difficulty sleeping		(

Hematological/Lymphatics:		
Easy bruising / bleeding	(	(
Anemia	(	(
Blood transfusions		(
Swollen lymph nodes	(	(
Lymphedema		(

Other symptoms not listed above: _____

Reviewed by Physician: _____ MD ***Date:*** _____

Reviewed by Phsycail Therapist: _____ MD ***Date:*** _____

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Q A Form for Patients

Name----------Date----------

Problem/injury/complaint----------

Please circle your pain over the past three days on a 1-10 scale:

0 1 2 3 4 5 6 7 8 9 10

0 = no pain
1 = slight pain
2 = mild pain
3 = low moderate pain
4 = moderate pain
5 = pain that intrudes on your concentration
6 = somewhat severe pain
7 = severe pain
8 = very severe pain
9 = almost intolerable pain
10= intolerable

Subsequent Dates:

(Please rate pain for the same problem)

Date	Pain Rating	Date	Pain Rating	Date	Pain Rating

Late Cancellation and No-Show Policy

Due to the high volume of patients trying to schedule appointments with both the Physicians and Therapists, Manhattan Physical Medicine & Rehabilitation Charges a **$25 fee** to all patients who do not show up to their scheduled appointments or do not cancel within 24hours.

By Signing below, you are agreeing to inform Manhattan PM&R of any Cancellations within 24 hours.

_____

Signature