

# HOSPITAL FOR JOINT DISEASES SPINE CENTER

301 East 17th St.  
New York, N.Y. 10003  
(212) 598-6625

Please print and fill-out in pen (not pencil) pages 1-4, prior to your appointment. Bring all pages of the New Patient Form with you on the day of your appointment.

(To be completed by all new patients prior to seeing Dr. Spivak, Dr. Bendo, Dr. Perry)

## DEMOGRAPHICS

Current Date:

Name:	Age:	Sex:
Social Security #:        -        -	Date of Birth:	
Street Address:		
City:	State:	Zip Code:
Marital Status (circle one):    Single    Married    Divorced    Widowed    Separated		
Home Phone: (    )		Cell Phone: (    )

Employer Name:	Occupation:	
Employer Address:		
City:	State:	Zip Code:
Business Phone: (    )		
Are you currently working?	If not, last date worked:	

Guardian /Insured's Name (if applicable):	
SS No.	DOB:
Address:	Phone:

Referred By:	Phone: (    )	
Address:		
City:	State:	Zip Code:

Primary Care Physician:	Phone: (    )	
Address:		
City:	State:	Zip Code:

Other Physician you would like a report sent to:		
Address:	Phone: (    )	
City:	State:	Zip Code:

INSURANCE INFORMATION  
(Choose applicable section)

**Private Insurance:**

Primary Carrier:	Phone: ( )
Address:	
City:	State: Zip Code:
Policy #:	Group #:

Secondary Carrier:	Phone: ( )
Address:	
City:	State: Zip Code:
Policy #:	Group #:

**Workers Compensation**

WCB Case #:	Carrier Case #:
Date of Injury:	
Insurance Carrier:	
Address:	
Claim Representative:	Phone: ( )

**No Fault**

Policy Holder:	Policy #:
Date of Accident:	File #:
Insurance Carrier:	
Address:	
Claim Representative:	Phone: ( )

***For Workers Compensation and No-Fault insurances:***

In accordance with regulations, I am aware that if no-fault is denied for my injuries, I am responsible for Dr. \_\_\_\_\_'s usual and customary fee for all services rendered to me or my dependents.

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

***For All Patients:***

**Authorization:** I hereby authorize Dr. \_\_\_\_\_ to furnish any records of services rendered to me or my dependents for purposes of review and evaluation for claims submitted to my insurance carrier. I also authorize medical benefits to be paid directly to this office for any services furnished that have not been paid by me.

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

**PAIN HISTORY**

If your pain is the result of an accident or injury, did you ever have similar pain prior to the accident or injury (circle one)? **YES NO**

If yes, please explain: \_\_\_\_\_

Have you had any of following treatments for your pain (If yes, give approximate dates)?

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

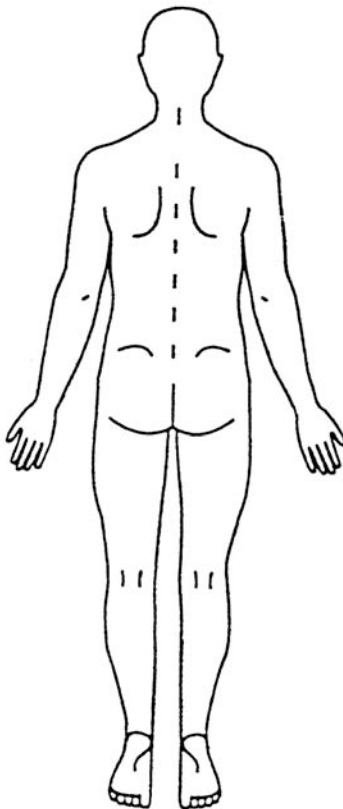
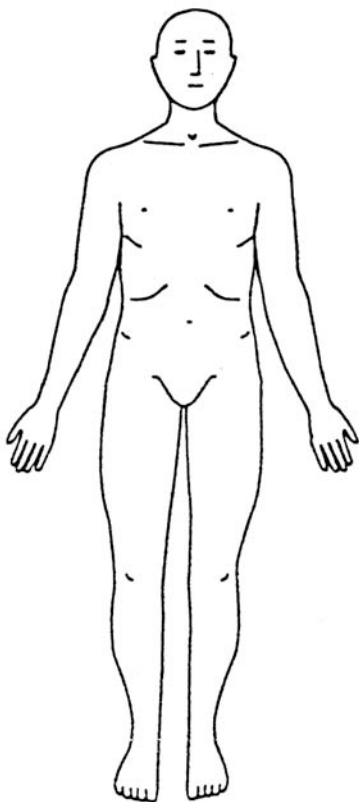
Chiropractic \_\_\_\_\_

Injections \_\_\_\_\_

Have you worn a corset or brace for your pain (circle one)? **YES NO**

Please mark the areas on this representation of your body where you feel the described sensations. Use the appropriate symbol. Mark all affected areas where the sensations travel.

<b>Numbness</b>	— —	<b>Tingling</b>	ooo	<b>Pain</b>	xxx
	— —		ooo		xxx
	— —		ooo		xxx



**MEDICAL HISTORY**

Have you had any fevers or chills in the past few months (circle one) **YES NO**

If yes, please describe:\_\_\_\_\_

Have you lost any weight over the past 6 months (circle one)? **YES NO**

If yes, how much?\_\_\_\_\_pounds

Please list all medications you are currently taking:

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

Do you have any allergies to medicines (circle one)? **YES NO**

If yes, to what?\_\_\_\_\_

Have you ever had any of the following? (**Y** for 'yes', **N** for 'no')

high blood pressure	_____	tuberculosis	_____
diabetes	_____	hepatitis	_____
asthma	_____	epilepsy	_____
heart attacks	_____	depression	_____
angina	_____	stomach ulcers	_____
heart failure	_____	cancer	_____
kidney problems	_____	HIV	_____
liver problems	_____	easy bruising	_____
emotional disorders	_____	drug problem	_____
drinking problem	_____	<i>other</i>	_____

Please list all prior surgeries of any type:

<b>TYPE</b>	<b>DATE</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you a smoker (circle one)? **YES NO** If yes, how many packs per day?\_\_\_\_\_

Do you drink alcohol (circle one)? **YES NO** If yes, how much?\_\_\_\_\_

How tall are you?\_\_\_\_\_feet\_\_\_\_\_inches How much do you weigh?\_\_\_\_\_pounds