Patient Data

Buffalo Neurosurgery Group

James G. Egnatchik, M.D. **P. Jeffrey Lewis, M.D.**

Edward Vargo, PA-C **Anthony Gagliardo, PA-C** **Rachel Kistner, PA-C** **Andrew Smith, FNP BC**

Megan Brown, PA-C **Alyssa Napieralski, CST** **Kara Colburn, RNFA** **Mark Szefler, RN**

Date / /

Is this visit related to a Motor Vehicle Accident? Yes ☐ No ☐

Is this visit related to a Work Injury? Yes ☐ No ☐

Have you been examined by any of the surgeons or practitioners listed above during the last 3 years? Yes ☐ No ☐

Please list allergies - If none, print "none"

Last Name	First Name	Middle Initial		
Address	City	State	Zip Code	
Your Employer	Occupation		Name of Spouse	
Employer Address	City	State	Zip Code	
Home Phone	Work Phone	Cell Phone	Email	Marital Status
Date of Birth	Age	Height	Weight	

Referring Doctor		Referring Doctor Phone #	
Referring Doctor Address	City	State	Zip Code
Family Doctor		Family Doctor Phone #	
Family Doctor Address	City	State	Zip Code
Person to Contact in the Event of an Emergency (In addition to your spouse) :		Phone Number of this Person:	
Pharmacy		Pharmacy Phone Number	
Pharmacy Address	City	State	Zip Code

Describe briefly your present symptoms:

Recent conservative care:

Physical therapy: Yes No

How long_____last visit date_____

Therapy Group:_____

Chiropractic: Yes No

How long_____last visit date_____

Chiropractor:_____

Injections: Yes No

PATIENT NAME _____ DOB _____

Past Medical History - Please circle or list any that you are being treated for:

Diabetes	Bladder disease	Mitral Valve Prolapse (MVP)
Heart disease	Tuberculosis (TB)	Kidney disease
Heart Attack	Ulcer	Hepatitis
Seizures	Hypertension	Thyroid
Lung disease	Stroke	Other - please list:
Liver disease	Cancer	
Bowel disease	Sexual dysfunction	

Past surgical history

Procedure	Date	Hospital

List any other serious injuries or diseases you have had:

Social History

Do you currently smoke?	Yes	No	How many packs per day?	How many years?
If NO have you ever smoked?	Yes	No	How many packs per day?	How many years?
If former smoker when did you Quit?				
Do you regularly drink?	Yes	No	How many drinks per week?	How many years?
Have you been treated for alcohol abuse?	Yes	No		
Have you been treated for drug abuse?	Yes	No		
Have you been treated for a psychiatric disorder?	Yes	No		

Please list any medications you are presently taking:

Medication	Doctor Prescribing

PATIENT NAME DOB

Do you know of any close relatives (parents, brothers, sisters, and children) who have had: (Circle and give relationship)

Stroke	Asthma	Heart Attack/Heart Disease	Cerebral Aneurysm
Alcoholism	Bleeding Tendency	Thyroid problem	Diabetes
High Blood Pressure	Epilepsy/Seizure Disorder	Back Surgery	Cancer
Other - Please describe:			

Demographics (Circle one that applies)

Race: White Black / African American American Indian / Alaska Native Asian

Native Hawaiian / Other Pacific Islander Other Patient Declined / Unknown

Ethnicity: Spanish / Hispanic Origin Not of Spanish / Hispanic Origin Patient Declined / Unknown

Review of Systems

Please circle the symptoms you have been experiencing recently:

General:	Weight loss	Fatigue	Weakness	Fever	Chills	Night sweats
HEENT:	Vision Changes	Hearing Loss	Ringing in ears	Nose bleeds		
Neck:	Pain/difficulty swallowing	Sore throat	Lumps/Masses in neck	Hoarseness		
Respiratory:	Shortness of Breath	Wheezing	Dry Cough	Productive Cough		
Cardiac:	Palpitations	Chest pain	Short of breath when lying down	Swelling in legs	Short of breath when exercising	
GI:	Nausea / Vomiting	Difficulty swallowing	Indigestion	Change in bowel habits	Blood in Stools	Weight loss
GU:	Difficulty Urinating	Pain on Urinating	Prostate Problems	Urinating multiple times at night	Blood in Urine	
Vascular:	Pain in calves when walking	Clots in legs				
Musculoskeletal:	Pain/stiffness in bones or joints	Arthritis	Gout	Muscle Weakness		
Neurologic:	Numbness / weakness	Tingling	Tremors	Seizures	Blackouts	Headaches
Hematologic:	Easy Brusing / Bleeding					
Endocrine:	Heat / Cold intolerance	Excessive Thirst				
Skin:	Skin, hair or nail Changes	Rashes	Sores			
Psychiatric:	Depression	Anxiety	Thoughts of Suicide			

PATIENT NAME _____ DOB _____

Your Insurance

Type of Insurance	Subscriber Name	Subscriber Date of Birth
Policy or ID number	Phone Number	Relationship

Other Insurance That Covers You (Secondary Insurance)

Type of Insurance	Subscriber Name	Subscriber Date of Birth
Policy or ID number	Phone Number	Relationship

Have you ever been hurt at work? YES ☐ NO ☐
If YES Please fill out all information:

Employer at time of injury - name and address (if different than current employer)

Compensation Carrier				Social Security Number
Compensation Carrier Address	City	State	Zip Code	Date of Injury
WCB #	Carrier Case Number		Carrier Phone Number	
Please describe how the injury/accident occurred:				Job Duty at Time of Injury

Were you ever hurt in an automobile accident? YES ☐ NO ☐
If YES Please fill out all information:

Insurance Carrier			Date of Injury
No Fault Carrier Address	City	State	Zip Code
Owner of policy	Policy Number or File Number		Ins. Carrier Phone Number

All patients - Please sign this section

I authorize payment of medical and surgical benefits by third party carriers directly to Buffalo Neurosurgery Group. I also authorize the release of medical information about me to third party carriers responsible for paying all or part of my medical and surgical fees as well as to suppliers of medical services requesting them.

Signature of Patient or Responsible Party _____ Date _____

I have been provided the Notice of Privacy Practices statement & Financial Policy of Buffalo Neurosurgery Group

Signature of Patient or Responsible Party _____ Date _____

Patients with Medicare sign this section also

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Buffalo Neurosurgery Group for any services furnished me by Buffalo Neurosurgery Group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to Pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed _____ Date _____
(Medicare Beneficiary)

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注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-716-677-6000