Jeffrey M. Spivak, M.D.

NYU HOSPITAL FOR JOINT DISEASES SPINE CENTER

240 East 18th Street
New York, NY 10003

311 North Street, Suite 102
White Plains, NY 10601

Patient Information

Name (Last, First, MI)			Today's Date
Street Address	City	State	Zip
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	
SSN	Date of Birth	Gender Male ☐ Female ☐	Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated □ Partner □ Other
Occupation:	Are you working currently: Yes ☐ No ☐	Email Address:	

Financially Responsible Party

Is patient responsible party/guarantor? □Yes □No (If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)

Name	Address	City/State/Zip	Relationship to Patient
Occupation	Employer	Email Address	Date of Birth
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	

Emergency Contact

Name	Relationship to Patient	
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

Referral Info

Referring Physician's Name	Physician Phone/Fax (if known) ( )
Physician Address	

PCP Info

Primary Care Physician's Name and Address(Check if same as Referring Physician above ☐)	Physician Phone ( )

Insurance Information

Primary Insurance Company	Policy #	Group #	
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Name of Subscriber (if other than patient)		
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone ( )
Secondary Insurance Company	Policy #	Group #	
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Name of Subscriber (if Other Than Patient)		
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone ( )

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Guarantor Signature (if other than patient): _____ Date: _____/_____/_____

MEDICAL HISTORY

Have you had any fevers or chills in the past few months? Yes ☐ No ☐
If yes, please describe:_____

Have you lost any weight over the past 6 months? Yes ☐ No ☐
If yes, how much? _____ pounds

Please list all medications and supplements you are currently taking (with dosages):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any allergies to medicines? 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	_____	thyroid disease	_____
osteoporosis	_____	rheumatoid arthritis	_____
other	_____		

Please list all prior surgeries of any type:

TYPE	**DATE**

Are you a smoker? Yes ☐ No ☐ If yes, how many packs per day?_____

Do you drink alcohol? Yes ☐ No ☐ If yes, how much?_____

How tall are you?_____ feet _____ inches How much do you weigh? _____pounds

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? 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 your worn a corset or brace for your pain? 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.

Numbness	———	**Tingling**	ooo	**Pain**	xxx
	———		ooo		xxx
	———		ooo		xxx