TODD J. MALTESE, D.O.
MARYANA LIEDKE, D.O.

Neurology, EMG, NCV, EEG, TCD, Sleep Medicine

650 Hawkins Avenue
Suite 7
Ronkonkoma, NY 11779
Phone: 631-737-0055
Fax: 631-737-0076
www.mmneurology.com

WELCOME TO OUR PRACTICE! We look forward to meeting you during your first visit.

Please complete **ALL PAGES** in the attached new patient packet and bring it with you to your appointment.

- Please provide complete and accurate insurance information, and bring your insurance card and photo ID with you.
- If your insurance company requires a referral, please obtain one from your primary care physician (PCP) and bring it with you to your visit.
- If you have had any ***bloodwork or diagnostic tests*** (i.e., **MRI's, CT scans, EMG/Nerve conduction tests, etc.**), please bring the written report and any films/disks with you to your appointment.
- If you are transferring care from another physician, please obtain and bring your medical records and prior doctor's notes with you.
- **All copayments and/or outstanding balances are due IN FULL at the time of your visit.** We accept cash, checks, and all major credit cards. If you cannot pay your copay at the time of your visit, there will be a $15 administrative fee added onto your bill.
- **We appreciate 24-hour notice for cancellations.** If you do not provide notice of cancellation within 24 hours prior to your scheduled visit, you will be charged **$25** for an office visit or **$100** for a testing visit. Thank you for your cooperation in this matter.

Prescription Medication Policy:

- Schedule your follow-up appointments to coincide with renewal of your medications.
- Controlled substances CANNOT be refilled by telephone.
- Any changes to medications will require an office visit.

Thank you for allowing us to be involved in your medical needs, and we look forward to seeing you soon! If you have any questions, please do not hesitate to contact our office during our regular business hours.

Sincerely,

The Staff of Dr. Todd J. Maltese and Dr. Maryana Liedke

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Last Name: _____ **First Name:** _____

Date of birth: ____/____/____ ☐ **Male** ☐ **Female**

Age: _____ **Height:** _____ **Weight:** _____

Why are you being seen in the neurology office? What are your concerns?

_____

_____

_____

_____

Primary Care Physician:

Name: _____

Address: _____

Telephone number: _____ Fax number: _____

Referring Physician (if different from Primary Care):

Name: _____

Address: _____

Telephone number: _____ Fax number: _____

MEDICATIONS Please list all of the medications that you currently take.

Medication name	Dose	Times Per Day	Medication name	Dose	Times Per Day
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

*Please use the bottom of page 2 if you need more room to list your medications.

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ALLERGIES Are you allergic to any medications? ☐ Yes ☐ No
*If yes, please list the medication and your reaction to it.

Medication name	Reaction	Medication name	Reaction
1.		4.	
2.		5.	
3.		6.	

PAST MEDICAL HISTORY Have you ever been diagnosed with or treated for the following?

☐ High blood pressure	☐ Parkinson's disease	☐ Cervical disc herniations
☐ Diabetes	☐ Dementia	☐ Lumbar disc herniations
☐ High cholesterol	☐ Seizures	☐ Fibromyalgia
☐ Heart disease and/or stents	☐ Multiple Sclerosis	☐ TMJ syndrome
☐ Cardiac arrhythmia and/or Afib	☐ Migraine headaches	☐ Depression
☐ Gastroesophagel reflux (GERD)	☐ Tension headaches	☐ Anxiety
☐ Thyroid disease	☐ Neuropathy	☐ Attention deficit disorder
☐ Concussion/Post-concussion	☐ Sleep apnea	☐ Substance abuse
☐ Stroke/TIA. Year? _____	☐ Cancer. What type(s)? _____	
Other medical problems:		

SURGICAL HISTORY

List all surgical procedures that you have had and their dates: _____

_____

_____

_____

_____

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SOCIAL HISTORY

Marital status: _____ Occupation: _____

Work status:

☐ Full time employment ☐ Retired ☐ Unemployed
☐ Part time employment ☐ Student ☐ Disabled

If no longer working, when was the last date that you worked? _____

Tobacco use:

☐ Never used tobacco products.
☐ Current smoker.
Average # of packs per day: _____ # of years smoking: _____
☐ Former smoker.
Quit date: _____ Average # of packs per day: _____ # of years smoked: _____

How often do you drink alcoholic beverages?

☐ Never ☐ Once or twice a week ☐ More than one drink per day
☐ Once or twice a month ☐ One drink per day ☐ Other: _____

FAMILY HISTORY

Has anyone in your immediate family had the following medical conditions?

	Mother	Father	Siblings	Other
High blood pressure				
Heart disease/Heart attacks				
Diabetes				
High cholesterol				
Stroke/TIA				
Brain aneurysm/vascular disease				
Epilepsy/Seizures				
Parkinson's disease				
Dementia				
Multiple Sclerosis				
Migraines/Chronic headaches				
Tremor				
Depression/Anxiety				
Alcohol or substance abuse				
Other psychiatric illness				
Cancer/Tumors (what type?)				

Mother: ☐ Living (Year she was born: _____) ☐ Deceased (Age when passed away: _____)

Father: ☐ Living (Year he was born: _____) ☐ Deceased (Age when passed away: _____)

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REVIEW OF SYSTEMS Check all boxes that apply to you ***AT THIS TIME***:

GENERAL	GASTROINTESTINAL	MUSCULOSKELETAL
☐ Fever or chills	☐ Heartburn	☐ Joint pain
☐ Fatigue	☐ Nausea or vomiting	☐ Muscle pain
☐ Weight loss or gain	☐ Constipation	☐ Muscle cramps
☐ Weakness	☐ Diarrhea	☐ Muscle twitching
EYES	☐ Abdominal pain	**NEUROLOGIC**
☐ Blurry vision	**ENDOCRINE**	☐ Headaches
☐ Double vision	☐ Heat intolerance	☐ Numbness/tingling
EAR/NOSE/THROAT	☐ Cold intolerance	☐ Tremor
☐ Hearing loss	**BLOOD**	☐ Trouble with balance
☐ Congestion/Sinusitis	☐ Anemia	☐ Confusion
☐ Ringing in your ears	☐ Easy bruising/bleeding	☐ Dizziness/lightheadedness
CARDIOVASCULAR	**URINARY**	☐ Memory loss
☐ Chest pain	☐ Urinate frequently	☐ Difficulty swallowing
☐ Palpitations	☐ Urinary incontinence	☐ Speech difficulty
☐ Swelling of feet	**SKIN**	**PSYCHIATRIC**
RESPIRATORY	☐ Rashes	☐ Anxiety/nervousness
☐ Shortness of breath	☐ Dryness	☐ Depression
☐ Cough		☐ Hallucinations
☐ Wheezing		

DEMOGRAPHICS Please check all that apply.

Race: ☐ American Indian ☐ Asian ☐ Hawaiian or Pacific Islander
☐ Hispanic ☐ White ☐ Black or African American
☐ Other Race: _____ ☐ Refuse to Report

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Refuse to Report

Language: ☐ English ☐ Spanish ☐ Other: _____

Registration Form (please print clearly) **Date:** _____

PATIENT INFORMATION

Patient Name: _____ E-mail Address: _____

Street Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Social Security #: _____-_____-_____ Birth Date: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Are you presently working: ☐ Yes ☐ No

Employer's Business Name: _____ Occupation: _____

Employer's Address: _____
(street address) (city) (state) (zip)

Employer's Phone Number: _____ Is this related to an accident? ☐ Yes ☐ No

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____
(street address) (city) (state) (zip)

PRIMARY INSURANCE INFORMATION

Insured's Name: _____ Insured's Date of Birth: _____/_____/_____

Insured's Address (if different than patient): _____
(street address) (city) (state) (zip)

Insured's Social Security #: _____-_____-_____ Relationship to Patient: _____

Insured Employed By: _____ Address: _____

_____

Insurance Company Name: _____ Insurance Phone Number: _____

Insurance Company Address: _____
(street address) (city) (state) (zip)

I.D. Number: _____ Group Number: _____

SECONDARY INSURANCE INFORMATION (*if applicable*)

Secondary Insurance Company Name: _____ Insurance Phone Number: _____

Insurance Company Address: _____
(street address) (city) (state) (zip)

I.D. Number: _____ Group Number: _____

Insured's Name (if different than above): _____ Insured's Date of Birth: _____/_____/_____

Insured's Address (if different than above): _____
(street address) (city) (state) (zip)

Insured's Social Security #: _____-_____-_____ Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____,
(name of insurance company)

and assign directly to Todd J. Maltese, DO, PC, all insurance 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 insurance submissions.

_____ _____ _____/_____/_____

Responsible Party Signature **Relationship** **Date**

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OFFICE POLICIES

Insurance/Referral Policy:

- It is the responsibility of the patient to ensure that his or her insurance information is up-to-date. If a claim is denied due to a change in insurance, and our office was not notified of this change prior to your office visit, you may be responsible for the cost of the entire medical bill. ALWAYS keep us updated with any changes in insurance.
- A copy of your valid insurance card must always be on file in our office.
- If your insurance company requires a referral, it is your responsibility to obtain one from your primary care physician (PCP) and bring it with you to your visit. You cannot be seen if you require a referral and you do not have one at the time of your visit.

Copay/Balance and Cancellation/No-Show Policy:

- All copayments and/or outstanding balances are due IN FULL at the time of your visit, or you might not be able to be seen. If you do not pay your copay at the time of your visit, there will be a $15 administrative fee added onto your bill.
- We appreciate 24-hour advanced notice for cancellations. If you do not provide notice of cancellation prior to your scheduled visit, you will be charged:

$25 for an office visit or **$100 for a testing visit**

Prescription Medication Policy:

- Schedule your follow-up appointments to coincide with renewal of your medications. Please note that if needed, renewing non-controlled medications by phone may take up to 3 business days to be processed, so please plan accordingly.
- Controlled substances CANNOT be refilled by telephone.
- Any changes to medications will require an office visit.

I have read and agree to the above office policies for the practice of Todd J. Maltese, D.O., P.C.

_____ _____

Patient Signature Date

_____

Patient Name (printed)

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Health Insurance Portability and Accountability Act (HIPAA)

This consent is given to the office of Todd J. Maltese, DO, PC, to use and disclose my individually identifiable health information for the specific purposes of obtaining payment from my health plan, providing appropriate treatment, and performing permissible healthcare medical procedures.

These specific uses and disclosures are permitted under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide to such restrictions.

I have the right to revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

I hereby grant permission that phone calls for the purpose of confirming or canceling appointments may be made to my home phone number, and messages may be left on answering machines.

My contact for emergencies is listed below. In addition, I ☐ DO ☐ DO <u>NOT</u> give you permission to speak with him/her in regards to my routine healthcare matters or concerns:

_____ _____

Name of emergency contact Phone Number

_____

Relationship

I consent to the above privacy practices of the office of Todd J. Maltese, D.O., P.C.

_____ _____

Patient Signature Date

_____

Patient Name (printed)

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MEDICAL RECORDS RELEASE AUTHORIZATION

To: _____

_____

_____

Kindly release a copy of my medical records, lab reports, and/or diagnostic test results to Todd J. Maltese, D.O., P.C. I have been advised and I understand that my medical records and information are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I hereby authorize the release of the above requested medical records.

_____ _____

Signature Date

_____ _____

Print Name Date of Birth