# 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 condition is the result of an accident, you must provide us with all of your accident insurance information, such as No Fault or Workers' Compensation insurance carrier, date of accident, adjuster or contact phone numbers, and attorney information.
- 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: _____

Do you have an attorney? ☐ Yes ☐ No

Attorney's Name: _____ Address: _____

_____

Attorney's Phone Number: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

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

## NO FAULT INSURANCE INFORMATION

Date of Accident: _____/_____/_____

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

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

Relationship to Patient: _____

Insurance Company Name: _____ Insurance Phone Number: _____

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

Claim Number: _____ Policy Number: _____

Case Manager's Name: _____ Case Manager's Phone Number: _____

Has any portion of your No Fault benefits been denied? ☐ Yes ☐ No

If yes, please explain: _____

_____

## 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**

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ (Print patient's name), **("Assignor") hereby assign to** Todd J. Maltese, D.O. (Print hospital or health care provider name), **("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.**

**The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ (Print accident date), not withstanding any other agreement to the contrary.**

**This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

| | |
|---|---|
| **(Print name of Patient)** | **(Signature of Patient)** |
| | (Date of signature) |
| (Address of Patient) | |
| Todd J. Maltese, D.O. **(Print name of Provider)** | **(Signature of Provider)** |
| 650 Hawkins Avenue - Suite 7 | (Date of signature) |
| Ronkonkoma, NY 11779 (Address of Provider) | |

NYS FORM NF-AOB (Rev 1/2004)

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## LIEN

DATED: _____

TO: Todd J. Maltese, D.O., P.C.
650 Hawkins Avenue – Suite 7
Ronkonkoma, NY 11779

PATIENT: _____

I, the undersigned, in consideration of medical services rendered to me at the office of Todd J. Maltese, D.O., P.C., for injuries sustained in an accident which occurred on _____/_____/_____ and for the treatment of which I am indebted to said doctor do hereby authorize my attorney indicated below to deduct and pay over to the aforementioned doctor, the sum of services rendered out of any money that may become payable by reason of the claim, suit, or settlement brought to recover damages.

ATTORNEY: _____

ADDRESS: _____

PHONE: _____ FAX: _____

_____ _____
PATIENT SIGNATURE ATTORNEY SIGNATURE

_____
WITNESS

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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