



# TODD J. MALTESE, 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

**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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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?

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Cervical disc herniations
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dementia	<input type="checkbox"/> Lumbar disc herniations
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Seizures	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Heart disease and/or stents	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> TMJ syndrome
<input type="checkbox"/> Cardiac arrhythmia and/or Afib	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Depression
<input type="checkbox"/> Gastroesophagal reflux (GERD)	<input type="checkbox"/> Tension headaches	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Attention deficit disorder
<input type="checkbox"/> Concussion/Post-concussion	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Stroke/TIA. Year? _____	<input type="checkbox"/> 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
<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Muscle pain
<input type="checkbox"/> Weight loss or gain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Muscle cramps
<input type="checkbox"/> Weakness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Muscle twitching
<b>EYES</b>	<input type="checkbox"/> Abdominal pain	<b>NEUROLOGIC</b>
<input type="checkbox"/> Blurry vision	<b>ENDOCRINE</b>	<input type="checkbox"/> Headaches
<input type="checkbox"/> Double vision	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Numbness/tingling
<b>EAR/NOSE/THROAT</b>	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Tremor
<input type="checkbox"/> Hearing loss	<b>BLOOD</b>	<input type="checkbox"/> Trouble with balance
<input type="checkbox"/> Congestion/Sinusitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Confusion
<input type="checkbox"/> Ringing in your ears	<input type="checkbox"/> Easy bruising/bleeding	<input type="checkbox"/> Dizziness/lightheadedness
<b>CARDIOVASCULAR</b>	<b>URINARY</b>	<input type="checkbox"/> Memory loss
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Urinate frequently	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Speech difficulty
<input type="checkbox"/> Swelling of feet	<b>SKIN</b>	<b>PSYCHIATRIC</b>
<b>RESPIRATORY</b>	<input type="checkbox"/> Rashes	<input type="checkbox"/> Anxiety/nervousness
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Dryness	<input type="checkbox"/> Depression
<input type="checkbox"/> Cough		<input type="checkbox"/> Hallucinations
<input type="checkbox"/> 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: \_\_\_\_\_



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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



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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 NOT 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)

**Do you have (check all that apply)?**  DNR  
 Advanced Directive  Healthcare Proxy  None





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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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Patient Name: \_\_\_\_\_

## Statement of Patient Financial Responsibility

Our office appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for payment in full of your bill.

Many insurance companies have additional stipulations that may affect your coverage. It is ultimately your responsibility to know your coverage and benefits. You authorize Todd J. Maltese, DO, PC, to furnish information to insurance carriers concerning your care. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. It is also your responsibility to obtain referrals or authorizations required by the insurance carrier in order to be seen at our practice. Full payment for services provided is due at the time of services rendered, otherwise late fees or administrative fees may be charged.

You are responsible for payment of any deductible and copayment/coinsurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Some health insurance carriers require the patient to pay a co-pay for services rendered, and this is a contract between you and your insurance carrier.

*"I understand that I am responsible for copayments and deductible/coinsurance as dictated by my insurance carrier."*

Initial: \_\_\_\_\_

*"I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for additional collection fees of 30% and any other charges incurred in the collection of any balance due that is placed for collection."*

Initial: \_\_\_\_\_

### Co-Pay/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.**

Initial: \_\_\_\_\_

### Late Fees/Returned Check Fees

If you have a balance and a statement is generated, you will have 30 days to arrange payment with our office. If no payment is made within 30 days, a \$5 late charge will be added each month until a payment is made (\$5 for the first month, \$10 for the second month, and \$15 for the third month). If no payment is arranged with our office by the fourth month, your balance will be referred to a collections agency and you will incur additional fees as outlined above under "Statement of Patient Financial Responsibility."

If a check is returned for insufficient funds, you will be charged an additional fee of \$25 for the returned check.

Initial: \_\_\_\_\_

*"I have read the above policy regarding my financial responsibility to Todd J. Maltese, DO, PC, for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Todd J. Maltese, DO, PC. I understand that any amount remaining after such payment has been made by my insurance carrier becomes my responsibility (or the guarantor's if the patient is a minor)."*

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Signature of patient OR parent/guardian (if under the age of 18)

---

Date

---

Print Name