PATIENT NAME:______________________ BIRTHDATE:_____________ AGE:_______ Male or Female

ADDRESS:______________________________ CITY:__________________ ZIP:_______________

PHONE: (H)_______________ (W)_______________ (C)_______________ BEST# TO BE REACHED AT: H/W/C

EMERG CONTACT (NAME & PHONE #):_________________________ EMAIL ADDRESS_________________

MARITAL STATUS: S ( ) M ( ) D ( ) W ( ) ____

NAME OF SPOUSE/PARTNER / DATE OF BIRTH

SSN:_____________________ RACE:____________________ ETHNICITY:___________________

LANGUAGE PREFERENCE:_____________________________

FAMILY DOCTOR:_____________________ REFERRING DOCTOR:_____________________

PHARMACY NAME/ADDRESS/PHONE#:____

INSURANCE INFORMATION

<u>INJURED IN A MOTOR VEHICLE ACCIDENT?</u> YES ( ) NO ( ) IF YES, YOU NEED TO FILL OUT A THIRD FORM

<u>INJURED IN A WORK RELATED ACCIDENT?</u> YES ( ) NO ( ) IF YES, YOU NEED TO FILL OUT A THIRD FORM

REGULAR INSURANCE (WE WILL NEED YOUR INSURANCE CARD)

TYPE:_________________ IDENTIFICATION #:______________________ GROUP #:____________

POLICY HOLDER: ___________________________ RELATIONSHIP TO PATIENT:________________

POLICY HOLDER DOB:__________________ EMPLOYER OF POLICY HOLDER:__________________

DO YOU HAVE OTHER HEALTH INSURANCE? YES ( ) NO ( )

IF YES, TYPE:_____________________ IDENTIFICATION #:________________ GROUP #:_________

POLICY HOLDER: ___________________________ RELATIONSHIP TO PATIENT:________________

EMPLOYER OF POLICY HOLDER:____

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE FULL COST OF SERVICES RENDERED TODAY. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY FOR THE PROCESSING OF MY MEDICAL CLAIMS. I RECOGNIZE THAT IF 1) I HAVE NO INSURANCE 2) I HAVE HMO INSURANCE BUT FAIL TO OBTAIN A REFERRAL WHEN NECESSARY OR 3) ANY BALANCE DUE AFTER INSURANCE SETTLEMENT, THEN I AM PERSONALLY RESPONSIBLE. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID ON MY BEHALF TO LUTHRA MEDICAL ASSOCIATES. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ALL THE PARTIES WHO MAY BE RESPONSIBLE FOR PAYING MY TREATMENT. I CERTIFY THAT THE ABOVE PERSONAL AND INSURANCE INFORMATION IS ACCURATE.

SIGNATURE____________________________________ DATE_________________ (FLIP OVER)

PATIENT'S NAME__________________________________

MEDICAL INFORMATION

(PLEASE DO NOT LEAVE ANY BLANKS; IF SOMETHING DOES NOT APPLY PUT N/A IN THE SPACE PROVIDED)

DO YOU HAVE OR EVER HAD:

DIABETES: ☐YES or ☐NO **HEART DISEASE: :** ☐YES or ☐NO **ARTHRITIS: :** ☐YES or ☐NO

LUNG PROBLEMS: : ☐YES or ☐NO **KIDNEY DISEASE: :** ☐YES or ☐NO **HIGH BLOOD PRESSURE: :** ☐YES or ☐NO

CANCER: ☐YES or ☐NO **THYROID:** ☐YES or ☐NO **OTHER:**____

HEIGHT________________ **WEIGHT**____________________

DO YOU HAVE ANY ALLERGIES TO:____________ **FOOD:**_________________________________

(PLEASE PUT NONE OR N/A ON THE LINE IF YOU HAVE NO ALLERGIES)

DRUGS:________________________________

IODINE:________________________________

ANY OTHER ALLERGIES?____

DO YOU CURRENTLY SMOKE? ☐YES or ☐NO IF YES HOW MUCH PER DAY?______ FOR HOW MANY YRS?_______

HAVE YOU EVER SMOKED? ☐YES or ☐NO IF YES HOW MUCH PER DAY?____________

WHEN DID YOU QUIT?________ **FOR HOW LONG DID YOU SMOKE BEFORE YOU QUIT?**__________

DO YOU SMOKE CIGAR? ☐YES or ☐NO **DO YOU SMOKE PIPE?** ☐YES or ☐NO

DO YOU CHEW TOBACCO? ☐YES or ☐NO

DO YOU DRINK ALCOHOLIC BEVERAGES? ☐YES or ☐NO **HOW MUCH/OFTEN?**__________________

HAVE YOU EVER HAD ANY COMPLICATIONS WITH ANESTHESIA? IF YES PLEASE DESCRIBE ☐YES or ☐NO

HAVE YOU BEEN TREATED FOR: DEPRESSION? ☐YES or ☐NO OR PSYCHOLOGICAL PROBLEMS? ☐YES or ☐NO

(IF YES, LIST)____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING THE DOSE:__________________

____

____

DESCRIBE MEDICAL PROBLEM THAT BRINGS YOU TO OUR OFFICE ___________________________________

ARE THERE ANY OTHER NEUROLOGIST OR NEUROSURGEONS? (   ) NO (   ) YES-DR.____________________

DATE LAST SEEN?________________________ REASON?____

LIST ALL ILLNESSES AND/OR HOSPITALIZATIONS/SURGERIES YOU HAVE HAD DURING YOUR LIFE:

____

____

FAMILY MEDICAL HISTORY:

MOTHER IS: ☐ALIVE ☐DECEASED AT AGE _____ OF DIABETES/HEART DISEASE/CANCER/OTHER:__________

FATHER IS: ☐ALIVE ☐DECEASED AT AGE _____ OF DIABETES/HEART DISEASE/CANCER/OTHER:__________

SIBLINGS: HOW MANY?________ ANY SIGNIFICANT HEALTH HISTORY:____________________ ☐DECEASED

PATIENT'S SIGNATURE____ DATE____________________

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

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

I, ____________________________, ("Assignor") hereby assign to ____________________________, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
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 __________________, not withstanding any other agreement
(Print accident date)
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)

____
(Print name of Provider)

____
(Signature of Provider)

____
(Date of signature)

____

____
(Address of Provider)

WORKERS COMPENSATION INFORMATION

DATE OF INJURY:____________________

1. NAME:___________________________ DATE OF BIRTH____________________

   ADDRESS: ________________________ TELEPHONE #: ____________________

   ________________________________ SS #:____________________________

2. EMPLOYER:________________________ TELEPHONE #:_____________________

   ADDRESS: ________________________

   ____

3. WORKERS COMPENSATION INSURANCE CARRIER _________________________________

   ADDRESS:________________________ TELEPHONE #:_____________________

   ____

   WCB CASE # (*if known*): ____

   CARRIER CASE # *(if known)*:____

4. HOW DID INJURY OCCUR AND WHAT WAS INJURED?_______________________________

   ____

   ____

5. WERE X-RAYS TAKEN? _____YES _____NO

   IF YES, WHERE?____

6. WERE YOU HOSPITALIZED? _____YES _____NO

7. FIRST DATE OF DISABILITY:____

8. ARE YOU CURRENTLY WORKING? ______YES ______NO

9. ARE YOU DISABLED FROM REGULAR DUTIES OR WORK? _____YES ____NO

I ________________________________ AM RESPONSIBLE FOR FULL PAYMENT TO DR. LUTHRA IF FOR ANY REASON WORKERS COMP SHOULD DENY.