Rick Weinstein, M.D.
Michael Gott, M.D.
Syed Rahman, M.D.

Westchester Sport and Spine
1133 Westchester Avenue
White Plains, NY 10604
914.358.9700

**WORKERS COMPENSATION INTAKE FORM**

I hereby authorize payment directly to WHITE PLAINS HOSPITAL for services rendered relating to an accident/injury covered under Workers Compensation insurance benefits.

I hereby authorize the provider of these services to release any medical records relating to my claims to my insurer liable for payment of such claim.

In the event the provider's charges are outstanding and / or fail to file an application for benefits under New York State Insurance law, I understand that I am personally responsible for the payment of the charges related to my claim.

Patient's Name ________________________________________ Date of Birth __________________________

Address: _________________________________________________________ Phone # _________________

Is this visit the result of an accident? At work ☐

Automobile ☐

DATE OF ACCIDENT: ______________________________ TIME OF ACCIDENT: _______________________

EMPLOYER NAME: ________________________________________ Phone # _________________________

EMPLOYER ADDRESS: ________________________________________________________________________

How did accident / injury occur? ______________________________________________________________

Body Parts established in WC Case: ____________________________________________________________

Workers Comp Board Number __________________ Carrier Case # _______________________________

Address for insurance claims (not the agent): ____________________________________________________

Insurance Co Address: ______________________________________________________________________

Adjuster's Name & Phone # __________________________________________________________________

Adjusters Fax # __________________________________

Attorney's Name & Phone #: _________________________________________________________________

PATIENT SIGNATURE: ________________________________ DATE: _______________________________

PLEASE NOTE THAT FAILURE TO PROVIDE US WITH THE APPROPRIATE CLAIM INFORMATION AND OR FAILURE TO FILE A CLAIM WITH YOUR INSURER WILL NECESSITATE US REQUIRING PAYMENT FROM YOU AT THE TIME OF SERVICE.

Rick Weinstein, M.D.
Michael Gott, M.D.
Syed Rahman, M.D.

Westchester Sport and Spine
1133 Westchester Avenue
White Plains, NY 10604
914.358.9700

**NO FAULT INTAKE FORM**

I hereby authorize payment directly to WHITE PLAINS HOSPITAL for services rendered relating to an accident/injury covered under NO FAULT insurance benefits.

I hereby authorize the provider of these services to release any medical records relating to my claims to my insurer liable for payment of such claim.

In the event the provider's charges are outstanding and / or fail to file an application for benefits under NO FAULT law, I understand that I am personally responsible for the payment of the charges related to my claim.

Patient's Name ________________________________________ Date of Birth __________________________

Address: _________________________________________________________ Phone # _________________

DATE OF ACCIDENT: ___________________________________ TIME OF ACCIDENT: _____________AM / PM

How did accident occur? ______________________________________________________________________

CLAIM # _________________________________ POLICY # __________________________________________

Address for insurance claims (not the agent): ______________________________________________________

Insurance Co Address: _________________________________________________________________________

Agent's Name & Phone # _______________________________________________________________________

Agent's Fax # _________________________________

PATIENT SIGNATURE: ________________________________ DATE: _______________________________

PLEASE NOTE THAT FAILURE TO PROVIDE US WITH THE APPROPRIATE CLAIM INFORMATION AND OR FAILURE TO FILE A CLAIM WITH YOUR INSURER WILL NECESSITATE US REQUIRING PAYMENT FROM YOU AT THE TIME OF SERVICE.

Rick Weinstein, M.D.
Michael Gott, M.D.
Syed Rahman, M.D.

Westchester Sport and Spine
1133 Westchester Avenue
White Plains, NY 10604
914.358.9700

# Patient Demographics

Patient's Last Name ____________________________ First Name _______________________ Middle Initial _______

SSN _____________________________ Date of Birth _______________ Age ___________ Gender F M

Address ______________________________ Apt. # _______ City ________________________ State _____ Zip ______

Race:
☐ American Indian/Alaska Native ☐ Asian ☐ White
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer Preferred Language: _________________

Marital Status: ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Separated Student Status ☐FT ☐PT

Home Phone ______________________________________ Day Phone ___________________________________

Email Address _____________________________________ Cell Phone ___________________________________

Employer _______________________________________ Occupation _______________________________ ☐Retired?

Employer Address ___________________________________________________________________________________

Emergency Contact _______________________________/_____________________ Phone _______________________
Name Relationship

***Primary Care Physician*** Name: ________________________________________ Phone:__________________________

***Referring Physician*** Name: ___________________________________________ Phone: __________________________

Pharmacy Name: _____________________________________________ Phone: _______________________________

Pharmacy Address: ___________________________________________________________________________________

***Primary*** Insurance Coverage: _______________________________________________________________________

Policy Holder Name: _______________________________________ SSN:____________________ DOB:___________

***Secondary*** Insurance Coverage: _____________________________________________________________________

Policy Holder Name: ______________________________________ SSN: _____________________ DOB: ___________

This visit is covered by: ☐ No Fault Insurance ☐ Workers' Compensation _____________________________________
I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature ___________________________________________________ Date________________
Responsible Party Name _________________________________________________ Relationship _______________

Rick Weinstein, M.D.
Michael Gott, M.D.
Syed Rahman, M.D.

Westchester Sport and Spine
1133 Westchester Avenue
White Plains, NY 10604
914.358.9700

## Patient History Form

**Name:** ______________________________________________ **Date of Birth:** _________________________

**Reason for Visit:**

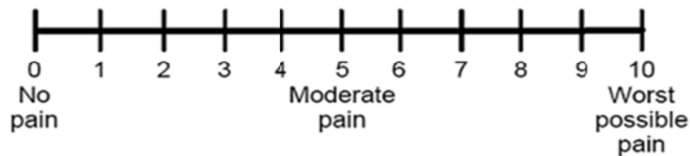
______________________________________________________________________________________________

____________________________________________________________________________________________

| **Please List All Current Medications** | | | ☐ **Not Currently Taking Any Medications** | | |
|---|---|---|---|---|---|
| Medication Name | Dosage | How Often Taking | Medication Name | Dosage | How Often Taking |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| **Allergies (e.g. medication, latex, egg)** | | ☐ **No Known Allergies** | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please indicate (circle) your current pain scale in relation to your current condition:




How would you prefer that we contact you?

☐ Home Phone ☐ Cell Phone ☐ Work/Day Phone ☐ Patient Portal

☐ Home Address ☐ Other ____________________________________________________________________

Patient Signature: _______________________________________________ Date: ____________________

Patient Representative Signature:_________________________________ Relationship: _______________

Rick Weinstein, M.D.
Michael Gott, M.D.
Syed Rahman, M.D.

Westchester Sport and Spine
1133 Westchester Avenue
White Plains, NY 10604
914.358.9700

**NAME:** ___________________________________ **AGE:** ______ **DOB:** ______________ **DATE:** _____________

Reason for today's visit: ____________________________________________________________________

**MEDICAL CONDITIONS (circle all that apply):**

| | | |
|---|---|---|
| Blood Pressure (High / Low) | Thyroid Disease | Diabetes |
| Stroke | Cholesterol | Heart Attack |
| HIV / AIDS | Hepatitis | |

List any prior surgeries (please include the year of surgery)

___

___

___

| | | |
|---|---|---|
| Have you ever had general anesthesia? | NO | YES |
| If YES were there problems? | NO | YES |

**FAMILY HISTORY**

| Member of Family | Alive | Deceased | Age | Health status or cause of death |
|---|---|---|---|---|
| Father | A | D | ____ | _______________________________________ |
| Mother | A | D | ____ | _______________________________________ |
| Sister (s) | A | D | ____ | _______________________________________ |
| Brothers (s) | A | D | ____ | _______________________________________ |

Any other family illness that may be pertinent ___________________________________________

**SOCIAL HISTORY**

History of Substance Abuse NO YES

I currently drink alcohol / beer Never Daily 1 – 2 x /wk 1 – 2 x /mo 1 – 2 x/yr

I smoke tobacco products NO YES I quit smoking ________________

I currently smoke _____ packs / day for the past ______ years

Caffeine NO YES

Type Coffee Chocolate Energy Drinks Soda Tea Tablets

Amount Daily ______________

Have you had any falls in the last year? ☐ Yes ☐ No If Yes, please state the number of falls: ___________

Did the fall(s) result in injury? ☐ Yes ☐ No Do you use any assistive devices? ☐ Yes ☐ No

Have you recently felt physically or emotionally harmed? ☐ Yes ☐ No

Rick Weinstein, M.D.
Michael Gott, M.D.
Syed Rahman, M.D.

Westchester Sport and Spine
1133 Westchester Avenue
White Plains, NY 10604
914.358.9700

NAME: ___________________________________________ DOB: _________________________________

Allergies to Medications / Food ☐ None

_________________________________________________________________________________________

_________________________________________________________________________________________

Height: ________________________ Weight: _______________________

Dominate Hand (circle) Right Left Ambidextrous

Is it possible you are currently pregnant (circle)?: Yes No

REVIEW OF SYSTEMS:
Are you currently having or have you had problems with?:

| | Circle | Describe all yes responses |
|---|---|---|
| Chills, Fever, Sweats | Y N | ________________________________________ |
| Weakness | Y N | ________________________________________ |
| Weight (gain/loss) | Y N | ________________________________________ |
| Eyes | Y N | ________________________________________ |
| Headaches | Y N | ________________________________________ |
| Ear problems/ Hearing | Y N | ________________________________________ |
| Chest Pain | Y N | ________________________________________ |
| Bleeding problems | Y N | ________________________________________ |
| Cough | Y N | ________________________________________ |
| Asthma, COPD | Y N | ________________________________________ |
| Difficulty Breathing | Y N | ________________________________________ |
| Skin issues | Y N | ________________________________________ |
| Cancer | Y N | ________________________________________ |
| Heart Problems | Y N | ________________________________________ |
| Seizures /Tremors | Y N | ________________________________________ |
| Fainting / Blackout | Y N | ________________________________________ |
| Bleeding / Bruising | Y N | ________________________________________ |
| Urination Issues | Y N | ________________________________________ |
| Psychological Problems | Y N | ________________________________________ |
| Hot / Cold Intolerance | Y N | ________________________________________ |
| Difficulty walking | Y N | ________________________________________ |
| Numbness / Tingling | Y N | ________________________________________ |
| Liver Disease | Y N | ________________________________________ |
| Thyroid Disease | Y N | ________________________________________ |
| Arthritis / Gout | Y N | ________________________________________ |
| AIDS (may leave blank) | Y N | ________________________________________ |
| Hepatitis | Y N | ________________________________________ |
| Digestion Disorder | Y N | ________________________________________ |

Above information was reviewed and any addition / changes to the form were noted.

______________________________________ ______________________________

PROVIDERS SIGNATURE DATE