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

WP HOSPITAL physician associates

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.

WP HOSPITAL physician associates

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

## Patient History Form

**Name:** _____ **Date of Birth:** _____

**Reason for Visit:**

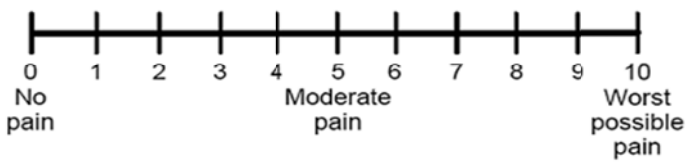
_____

_____

| **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.

WP HOSPITAL physician associates

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.

WP HOSPITAL physician associates

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