HENRY M. SPINELLI, M.D., P.C., F.A.C.S.
875 FIFTH AVENUE
NEW YORK, NEW YORK 10065
(212) 570-6235
FAX (212) 570-4168

Plastic & Reconstructive Surgery Craniofacial & Oculoplastic Surgery

Today's Date:_____

Last Name:_____ First Name:_____ Middle Name:_____

If Patient is a Minor, Names of Parents: _____

Address:_____ Apt #_____ City: _____ State: _____ Zip:_____

Home Phone:( ) _____Cell Phone:( ) _____ Date Of Birth:___/ ___/___

SS#:_____ Email:_____ Marital Status:_____

Occupation:_____ Employer:_____ Work #_____

Emergency Contact:_____**Relationship:**_____

Cell:( )_____ Home:( ) _____ Work:( )_____

Mother's Maiden Name (First, Last) : _____ **Father's Full Name (First, Last)** _____

Primary Care Physician:_____ Phone #: ( )_____

Street Address:_____City: _____ State:_____Zip:_____

Who Referred You to This Office?:_____

Reason for This Consultation:_____

Patient History: Do You Have or Had Any of the Following Conditions? (Check All That Apply).

□ Arthritis	□ Cardio Vascular	□ Hypertension	□ Pneumonia	□ Autoimmune Disease
□ Asthma	□ Glaucoma	□ Migraines	□ Lupus	_____
□ Blood Disorders	□ Cataracts	□ Myocardial Infarction	□ Thyroid Disease	Other _____
□ Cancer	□ Diabetes	□ Lung Disease (chronic, ie, emphysema)	□ Dry Eyes	_____

Do You Smoke?: _____ How Much?:_____ Do You Use Alcohol?: _____ How Often?:_____

Recent Weight Change □ Gain □ Loss _____ Do You Exercise?:_____ Contact Lenses?:_____

Past Surgical Procedures:_____

_____

Medications: Please List All Medications You Are Using Including Aspirin, Anti-Inflammatories (i.e., Motrin) or Vitamins:

_____

_____

Allergen (i.e. Penicillin)	**Reaction**

Family History — Has Any Member of Your Family Had or Currently Have: (Circle All That Apply)

Arthritis Cancer Diabetes Glaucoma

Hypertension Other Significant History: _____

INSURANCE INFORMATION:

Primary Insurance Carrier:_____ Policy #: _____ Group #:_____

Name of Insured (if not self):_____ SS#: _____ DOB:_____

Employer's Name: _____Relationship to Patient:_____

Secondary Insurance Carrier:_____ Policy #: _____ Group #:_____

Name of Insured (if not self):_____ SS#: _____ DOB:_____

Employer's Name: _____Relationship to Patient:_____

PAYMENT OF BENEFITS:

I, the undersigned, fully consent to this consultation and to future office visits. I acknowledge responsibility for the payment of all services. Any non-covered services (not paid for by my insurance plan), as well as all co-payments and deductibles will be my responsibility. I authorize payment of benefits, as determined by my insurance company, directly to the physician.

Patient's Signature:_____ Date:_____

Signature of Insured Party: _____ Date:_____

MEDICAL RECORDS RELEASE AUTHORIZATION:

I authorize any insurance company, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to my treatment and the processing of medical claims. To the best of my knowledge the information I furnish is complete and accurate.

Patient's Signature:_____ Date:_____

MEDICARE PATIENTS ONLY: PATIENT MUST READ AND SIGN PRIOR TO TREATMENT

Please be advised that Dr. Spinelli has opted out of the Medicare program. If you are a Medicare beneficiary and we have not already provided a copy of our private contract for you to read and sign please request one now before services are rendered to you by Dr. Spinelli. We cannot submit claims to Medicare for reimbursement to our office nor on your behalf and all payments are the responsibility of the patient.

Please note that although we have opted out of the Medicare program this will not affect your benefits for hospital, pathology or anesthesia services nor will it affect other consultative physicians who remain Medicare providers.

Please verify that you have read and understand the above statement by signing below. Thank you.

Patient's Signature:_____ Date: _____

Disclosure Information:
Please be advised when being treated in this office; Henry M. Spinelli, M.D., Henry M. Spinelli, M.D., P.C. and Dana Care, LLC, utilize the following entities:

Deborah L. Moody, M.D. Anesthesiologist Tel. 914-656-3640 or dlmoodymd@aol.com
For Billing:
Porteck
P.O. Box 155
Center Moriches, New York 11934

East River Medical Imaging, PC
519 East 72nd St., Suite 103 New York, NY 10021 Tel.212-288-1575 www.eastriverimaging.com

Weill Cornell Imaging at New York Presbyterian Hospital
Outpatient Radiology
520 East 70th Street, ground floor New York, NY. 10021 Tel. 212-746-9729 or 212-746-6000

Weill Cornell Physicians, Dermatopathology Laboratory
1300 York Avenue, Room f-309
New York, NY 10065 Tel. 212-746-6445

Network Affiliation
Please be advised that Dr. Henry M. Spinelli, Henry M. Spinelli, M.D., P.C. and Dana Care, LLC does **not** participate with any insurance plans including Medicare, Medicaid, No-Fault or Workers Compensation.

Hospital Affiliation
Dr. Spinelli is affiliated with the following hospitals: Manhattan Eye and Ear Infirmary, New York Eye and Ear Infirmary, Lenox Hill Hospital and Yale-New Haven Hospital however his primary hospital for which he operates is:

New York Presbyterian Hospital – Weill Cornell Medical Center
525 East 68th Street and York Avenue, New York, New York 10021 Tel. 212-746-5454

Referral to a Non-Participating Health Care Professional
Henry M. Spinelli, M.D.,P.C. has referred you to what we feel is an optimal physician and or facility for your health care needs. This referral is based solely on our professional medical opinion and not on health care plan participation or lack thereof. While we make every reasonable effort to obviate unnecessary expenses on the part of any patient, we are unable to control financial issues outside of our office. Therefore, as the patient and potential consumer of elective medical services it is your personal responsibility to ascertain individual healthcare plan participation and other related financial considerations before being seen and or treated by or at any physicians, health care facilities, laboratories and other health care entities.

Acknowledgment of Receipt

_____Date:_____
Signature

_____
Print Patient Name

_____Relationship to Patient:_____
Print Name of Legal Representative or Guardian