

Westchester Spine and Brain Surgery, PLLC

280 North Central Ave., Suite 235

Hartsdale, NY 10530

Phone (914) 332-0396 Fax (914) 468-8895

<http://www.wsbsonline.com>

Bennie W. Chiles III, M.D., F.A.C.S.

Board Certified, American Board of Neurological Surgery
Fellow, American College of Surgeons

Dear Patient

Your neurosurgical appointment has been made with our office. Please fill out the enclosed forms and bring them with you on the day of your appointment. Directions are attached.

In order to make your visit with us as productive as possible, **YOU MUST BRING IN YOUR MRI OR CAT. SCAN FILMS** with you as well as the radiological report.

The doctor will be unable to make a complete diagnosis or properly recommend the appropriate treatment without viewing the actual films.

INSURANCE : IF REFERRAL FROM YOUR INSURANCE is required in order to see the doctor, please be sure to bring the referral with you . **IT IS THE PATIENTS RESPONSIBILITY TO OBTAIN THEIR REFERRAL OR PROPER AUTHORIZATION DIRECTLY FROM THE PRIMARY CARE PHYSICIAN BEFORE YOUR APPOINTMENT.** Also your insurance identification will be necessary. If your insurance requires a co-payment you will be responsible for that payment on the date of service. Without your insurance information or **REFERRAL** you will be asked to either pay for your visit or reschedule your appointment.

WORKERS' COMPENSATION OR NO-FAULT : The following information will be needed. Workers Compensation: Insurance name, address of insurance carrier, address of employee and the carrier case number, WCB number and date of injury along with telephone number and name of case worker. *We also will require that you supply us with your private insurance carrier for our records in addition to your compensation information.*

No Fault: (Automobile Accident) Insurance name, address of insurance carrier, file or claim number, name of insured person and date of the accident. *We also ask that you supply us with your private insurance for our records in addition to your no fault information.*

If you need to cancel, please call 24 hours in advance. Our office hours are Monday Thru Friday 9:00 a.m. to 5:00 p.m.

*****PLEASE NOTE *****

Due to the nature of our practice it sometimes becomes necessary to re-schedule patients' appointments in order to accommodate surgical emergencies. We appreciate your understanding.

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Dr. Bennie W. Chiles III, M.D. _____

Visit Date _____

PART I-PATIENT INFORMATION (Please Print)

Patient Name _____
First Middle Last

Reason for visit _____

Sex (M/F) ____ Age ____ Birthdate _____ SS# _____ Marital Status _____

Mailing address _____

City _____ State _____ Zip _____ Drivers license#/State _____

Phone numbers _____
Home Work Cell /pager

Street address (if different or PO Box written above) –

Street name and house/apt number _____

City _____ State _____ Zip _____

Employer _____
Name

Address _____ City _____ State _____ Zip _____

Referring Physician

Name _____

Address _____

City/State/Zip _____

Phone # _____

Primary Care Physician

Name _____

Address _____

City/State/Zip _____

Phone # _____

Patient Mother's name _____ **Patient Father's name** _____
First, MI, Last First, MI, Last

Emergency contact _____
Name Daytime Phone number Relationship to pt

Street address _____ City _____ State _____ Zip _____

PART II- INSURANCE INFORMATION

Accident/ injury claims:

Is the reason for this visit due to any type of accident or injury? Y ___ N ___

***If no, please skip this section and go to Health Insurance Information section at bottom of page.**

If yes, please explain cause of accident, date, and location of accident, and provide information requested below:

Workers Compensation/Auto accident claims:

Please indicate type of accident: Workers Compensation ___ No Fault (Auto) ___

Date of injury _____ Please indicate part of body injured _____

Insurance company name _____

Claims address/city/state/zip _____

Insurance co. phone # and contact name _____

Claim or file # _____ Is this claim active? _____

Policyholder _____ Relation to patient _____

Attorney name, address and phone # _____

Are you currently working? Y ___ N ___ If no, please indicate last day worked _____

For No-fault (Auto) claims only—Were you the:

Automobile Driver ___ Passenger ___ Pedestrian ___ Bicyclist ___ Motorcyclist ___

Motorcycle passenger ___ Other (specify) _____

For Workers Compensation claims only:

Employer responsible for injury _____

Responsible employer address/ph# _____

Your job title or duties at time of injury _____

HEALTH INSURANCE INFORMATION (please provide ID card(s) for copying)

Primary Insurance Check one: HMO ___ PPO ___ Medicare ___ Other _____

Insurance Co. name _____ Referral required? ___ Effective date _____

Insurance company claims address _____

Insurance co. phone number _____ Office Co-pay amount (if applicable) _____

Identification/policy # _____ Group/plan# _____

Subscriber information:

Name _____ Sex ____ Date of Birth _____ Marital Status ____

Social Security # _____ Relation to patient _____

Address (if different than patient) _____

Phone # (if different than patient) _____ Employer _____

Employer address _____

Work Phone# _____

SECONDARY INSURANCE **Check one:** HMO __ PPO__ Medicare ____ Other____

Insurance Co. name _____ Referral required? _____ Effective date _____

Insurance Co. claims address _____

Insurance Co. phone # _____ Office copay amount (if applicable) _____

Identification/policy # _____ Group/plan # _____

Subscriber information:

Name _____ Sex ____ Date of birth _____ Marital Status _____

Social Security # _____ Relationship to patient _____

Address (if different than patient) _____

Phone # (if different than patient) _____ Employer name _____

Employer address _____

Work phone # _____

Other information you would like to provide: _____

Thank you for your cooperation.

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Assignment and Release of Information

I hereby authorize Westchester Spine and Brain Surgery, PLLC and its agents the release of medical information necessary to process my medical claims and to physicians requesting consultation and third party payers responsible for all or part of the provider's fees.

Signature: _____ Date _____
(Patient, or parent if minor)

I hereby authorize assignment and payments of any medical benefits due me to Westchester Spine and Brain Surgery, PLLC and its agents. I agree to pay and all charges that exceed or that are not covered by my insurance.

Signature: _____ Date _____
(Patient, or parent if minor)

I request that payment of authorized medical benefits be made to or on my behalf to Westchester Spine and Brain Surgery, PLLC for services furnished by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services by the provider.

Signature: _____ Date _____
(Patient or authorized representative)

Name _____ Date of Birth _____

CHIEF COMPLAINT

WHAT IS YOUR CHIEF COMPLAINT (Why are you seeing the Doctor?)

Current problem is the result of a (n): Check what is applicable:

Car Accident: _____ Work Accident: _____ Accident: _____ Other: _____

Please list any prior major illnesses and/or injuries: _____

List any procedures/surgeries that you have had in the past:

SURGERIES	YEAR	COMPLICATIONS

HAVE YOU EVER HAD ANY PROBLEMS WITH ANESTHESIA: YES NO

LIST ANY MEDICATION THAT YOU ARE TAKING, INCLUDING DOSAGE & FREQUENCY

CURRENT MEDICATIONS	DOSE	FREQUENCY

LIST ANY ALLERGIES YOU HAVE (INCLUDING ASPIRIN):

ARE THERE ANY MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY: YES NO

PLEASE LIST: _____

SOCIAL HISTORY:

OCCUPATION: _____

MARITAL STATUS: ____ SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED

AGE: _____ RIGHT OR LEFT HANDED: _____ HEIGHT: _____ WEIGHT: _____

DO YOU SMOKE? YES ____ NO ____ IF YES HOW MUCH: _____

DO YOU DRINK? YES ____ NO ____ IF YES HOW OFTEN: _____

ARE YOU AT RISK FOR AIDS (SEXUAL ORIENTATION, DRUG ABUSE, PREVIOUS BLOOD TRANSFUSION)? YES ____ NO ____ IF YES, PLEASE EXPLAIN: _____

REVIEW OF SYSTEMS:

ARE CURRENTLY OR HAVE YOU HAD ANY PROBLEMS WITH:

FEVER	YES	NO
WEIGHT LOSS		
GLAUCOMA		
CATARACTS		
EAR, NOSE, OR THROAT AND MOUTH		
HEARING LOSS		
RINGING IN EARS RIGHT LEFT BOTH		
BALANCE DISTURBANCES (BALANCE/DIZZINESS)		
SINUS PROBLEMS		
SINUS HEADACHES		
CARDIOVASCULAR		
CHEST PAINS OR ANGINA- DATE OF LAST EKG		
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
RESPIRATORY		
ASTHMA		
CHRONIC COUGH		

INDIGESTION OR PAIN WITH EATING	YES	NO
NAUSEA		
VOMITING		
JAUNDICE		
CHANGE IN BOWEL HABITS		
ULCERS OR GASTRITIS		
URINARY TRACT INFECTIONS		
DIFFICULTY STARTING OR STOPPING STREAM		
ARM OR LEG WEAKNESS		
BACK PAIN		
ARM OR LEG PAIN		
ARTHRITIS		
ANXIETY		
DEPRESSION		
DIABETES		
INCREASED APPETITE		
HEMATOLOGIC/LYMPHATIC		
ANEMIA		
HEMOPHILIA		

LIST ANY PHYSICIANS THAT YOU WOULD LIKE THE DOCTORS OFFICE NOTE SENT TO: _____

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE:

PATIENT SIGNATURE

DATE

PROVIDERS SIGNATURE

DATE

Chaperone Policy

Patient Notification

Westchester Spine and Brain Surgery is committed to providing a safe, comfortable environment where patients and staff can be confident that best practice is being followed at all times and the safety of everyone is of paramount importance.

All patients are entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required. This chaperone may be a family member or a friend. On occasions you may prefer a formal chaperone to be present. Whenever possible, we would ask you to make this request at the time of booking appointments so arrangements can be made and your appointment is not delayed in any way. Where this is not possible, we will still endeavor to provide a formal chaperone at the time of your request. Rarely, it may be necessary to reschedule your appointment.

Your WSBS physician may also require a chaperone to be present for certain consultations in accordance with our chaperone policy.

If you would like to see a copy of our chaperone policy or have any questions/comments regarding this, please contact our office manager.