HOWARD LISS, M.D.
REHABILITATION INSTITUTE

Today's Date________________

DEMOGRAPHICS

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	SEX:	DATE OF BIRTH:

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

HOME PHONE:	MOBILE PHONE:	PREFERENCE Home Mobile	EMAIL:

SOCIAL SECURITY #:	OCCUPATION:	EMPLOYER:

EMPLOYER ADDRESS:	EMPLOYER PHONE #:

MARITAL STATUS: Married Single Divorced Widowed	LIVE Alone With _____________	NO. OF CHILDREN:	CHILDREN AGES:

EMERGENCY CONTACT:	RELATIONSHIP TO PATIENT:	PHONE #:

RACE: White African American Asian Other ___________	LANGUAGES SPOKEN: English Hebrew Spanish Other: Russian __________	ETHNICITY: Hispanic or Latino Not Hispanic or Latino

REFERRED TO DR. HOWARD LISS BY:

OTHER PHYSICIANS

Referring Physician:	**Phone #:**	**Do you authorize this physician to receive your medical records from Dr. Liss?** Yes No
Primary Care Provider:	**Phone #:**	**Do you authorize this physician to receive your medical records from Dr. Liss?** Yes No
Other Treating Physician:	**Phone #:** **Specialty:**	**Do you authorize this physician to receive your medical records from Dr. Liss?** Yes No
Other Treating Physician:	**Phone #:** **Specialty:**	**Do you authorize this physician to receive your medical records from Dr. Liss?** Yes No
Other Treating Physician:	**Phone #:** **Specialty:**	**Do you authorize this physician to receive your medical records from Dr. Liss?** Yes No
I authorize Howard Liss, MD and staff to obtain my pertinent medical records from other providers and medical facilities.		**Signature**___________________________

MEDICATIONS

PHARMACY NAME:	ADDRESS:	PHONE NUMBER:
		Please initial this box to allow the doctor to access your prescription history from your pharmacy.
ALLERGIES TO MEDICATIONS:		
CURRENT MEDICATIONS:		

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MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____	DOMINANT HAND: Right / Left	**TOBACCO SMOKING STATUS:** Never Smoker, Former Smoker, Current Smoker, Number of cigarettes/day:	**ALCOHOL INTAKE:** None, Occasional, Moderate, Heavy	**ILLEGAL DRUG USE:** None, Medical Marijuana, Recreational Marijuana, Other ______________

SOCIAL HISTORY

TOBACCO SMOKING STATUS:
Never Smoker
Former Smoker
Current Smoker
Number of cigarettes/day:

ALCOHOL INTAKE:
None
Occasional
Moderate
Heavy

ILLEGAL DRUG USE:
None
Medical Marijuana
Recreational Marijuana
Other ______________

VACCINATIONS

SEASONAL INFLUENZA (FLU) VACCINE	PNEUMONOCCAL (PNEUMONIA) VACCINE	COVID-19 (CORONAVIRUS) VACCINE
Not Received:	Not Received:	Not Received:
Approximate Date Received:	Approximate Date Received:	Approximate Date Received:

PAST MEDICAL HISTORY (check all that apply and elaborate if needed)

AUTOIMMUNE DISEASE:
Please Specify ____________
____
____

BONE/JOINT PROBLEMS:
Arthritis
Artificial Joints
Please Specify: __________
Carpal Tunnel
Frequent Falls
Gout
Osteoporosis/Osteopenia
Rheumatoid Arthritis
If Other, Please Specify:
____
____
____

CARDIOVASCULAR:
Anemia
Aneurysm
Arrhythmia (heart)
Blood Clotting Disorder
Bleeding Disorder
Congestive Heart Failure
Heart Attack
Date: ____________
High Blood Pressure
High Cholesterol
Pacemaker
Stroke
Date: ____________
If Other, Please Specify:
____
____
____

CANCERS:
Please Specify: __________
____
____
____
____

DIGESTIVE ISSUES:
Crohn's Disease
Constipation
Diabetes
Type 1 Type 2
Diverticulitis
Heartburn/Reflux/GERD
Hyperthyroidism
Hypothyroidism
Obesity
Ulcerative Colitis
If Other, Please Specify:
____
____
____

INFECTIOUS DISEASE:
AIDS/HIV
Lyme Disease
If Other, Please Specify:
____
____
____

KIDNEY/BLADDER:
Dialysis
Kidney Stones
Kidney Transplant
Urinary Problems
If Other, Please Specify:
____
____

LIVER PROBLEMS:
Hepatitis
If Other, Please Specify:
____
____

LUNG PROBLEMS:
Asthma
COPD
Sleep Apnea
Pulmonary Embolism
If Other, Please Specify:
____
____

MENTAL ILLNESS:
ADD/ADHD
Alcohol/Drug Abuse
Anxiety
Bipolar Disorder
Depression
Eating Disorder
OCD
Suicidal Thoughts
Schizophrenia
If Other, Please Specify:
____
____

NEUROLOGICAL:
Alzheimer's Disease
Dementia
Parkinson's Disease
Head Injury/Concussion
Migraines
Seizures/Epilepsy
If Other, Please Specify:
____
____
____

SKIN PROBLEMS:
Melanoma
Please Specify: __________
____

ANY OTHER MEDICAL CONDITIONS:
____
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MEDICAL HISTORY (CONT.)

SURGERIES AND PROCEDURES

SURGERY/PROCEDURE NAME	APPROXIMATE DATE

FAMILY HISTORY OF MEDICAL PROBLEMS
(M= Mother, F = Father, S = Sister, B = Brother, C = Child)

Diabetes	Cancer	Heart Disease	Neurological Disorder	Neck Problems	Back Problems	Joint Problems
M F S B C	M F S B C	M F S B C	M F S B C	M F S B C	M F S B C	M F S B C

Other Medical Problem: (please specify) ____ Relation: M F S B C

Other Medical Problem: (please specify) ____ Relation: M F S B C

SCREENINGS

BONE DENSITY	COLONOSCOPY	MAMMOGRAM (woman)	CARDIAC STRESS TEST
Date: _______________	**Date:** _______________	**Date:** _______________	**Date:** _______________
Results: Normal Osteopenia Osteoporosis	**Results:** Normal Abnormal_____________	**Results:** Normal Abnormal_____________	**Results:** Normal Abnormal_____________

REASON FOR TODAY'S VISIT

CHIEF COMPLAINT:

DO YOU HAVE DIFFICULTY OR PAIN WHEN PERFORMING ANY OF THE FOLLOWING?

Sitting	No Problem	Able with Pain	Difficulty	**Stairs**	No Problem	Able with Pain	Difficulty
Arising	No Problem	Able with Pain	Difficulty	**Cooking**	No Problem	Able with Pain	Difficulty
Driving	No Problem	Able with Pain	Difficulty	**Grooming**	No Problem	Able with Pain	Difficulty
Exercising	No Problem	Able with Pain	Difficulty	**Dressing**	No Problem	Able with Pain	Difficulty
Walking	No Problem	Able with Pain	Difficulty	**Feeding**	No Problem	Able with Pain	Difficulty

I also have pain while ____

My pain is alleviated/lessened by ____

OVERALL DAILY PAIN LEVEL ON A SCALE 0 TO 10 (0 = no pain; 10 = worst pain): __________

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MEDICAL HISTORY (CONT.)

REVIEW OF SYSTEMS (check all that apply)

CONSTITUTIONAL

Fevers	Chills	Significant Weight Gain of ____ lbs	Exercise Intolerance	Loss of Appetite
Night Sweats	Lethargy	Significant Weight Loss of ____ lbs	General Discomfort/Malaise	

EYES

Wears Contacts/Glasses	Dry Eyes	Eye Irritation	Recent Vision Change	Eye Disease/Injury

EARS/ NOSE/ MOUTH/ THROAT

Difficulty Hearing	Ear Pain	Nose Problems	Oral Abnormalities	Mouth Ulcer
Frequent Nosebleeds	Snoring	Sinus Problems	Teeth Abnormalities	Sinusitis
Bleeding Gums	Dry Mouth	Mouth Breathing	Chronic Sore Throat	Ringing in Ears

CARDIOVASCULAR

Chest Pain on Exertion	Shortness of Breath While Walking	Heart Palpitations	Light-headedness/faintness
Arm Pain on Exertion	Shortness of Breath While Lying	Ankle Swelling	Heart Murmur

RESPIRATORY

Chronic Cough	Wheezing	Trouble Breathing	Coughing Up Blood	Sleep Apnea

GASTROINTESTINAL

Stomach Pains	Frequent Nausea	Constipation	Dyspepsia	Black/Tarry Stools
Frequent Diarrhea	Frequent Vomiting	Vomiting Blood	Acid Reflux	Change in Appetite

GENITOURINARY

Urinary Loss of Control	Blood in Urine	Difficulty Urinating	Increased Frequency	Incomplete Bladder Emptying

MUSCULOSKELETAL

Swelling in Legs/Arms	Difficulty Walking	Neck Pain	Joint Pain	Osteoporosis
Muscle Weakness	Muscle Aches	Back Pain	Muscle Cramps	Fractures

SKIN/INTEGUMENTARY

Abnormal/New Mole	Rash	Dry Skin	Non-Healing Areas	Cuts/Lacerations	Breast Lumps
Skin Yellowing	Itching	Growths	Changes in Hair/Nails	Changes in Skin Color	

NEUROLOGIC

Loss of Consciousness	Weakness	Migraines	Seizures
Frequent/Severe Headaches	Numbness	Restless Legs	Dizziness
Uncoordinated Walking	Tingling	Tremor	Paralysis

PSYCHIATRIC

Feeling Unsafe in Relationship	Sleep Disturbances	Restless Sleep	Depression
Hallucinations	Memory Loss	Delirium	Anxiety
Agitation	Mood Swings	Dementia	Suicidal Thoughts

ENDOCRINE

Fatigue	Increased Thirst	Hair Loss	Increased Hair Growth	Cold Intolerance

HEMATOLOGIC/LYMPHATIC

Swollen Glands	Easy Bruising	Excessive Bleeding	Anemia	Vein Inflammation

ALLERGIC/IMMUNOLOGIC

Runny Nose	Sinus Pressure	Itching	Hives	Frequent Sneezing

I certify that my medical history information I provided above is correct and accurate to the best of my knowledge.

Signature ______________________________ Date ________________

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INSURANCE INFORMATION

PRIVATE INSURANCE & MEDICARE (ALL PATIENTS)

PRIMARY INSURANCE TYPE:	
MEMBER ID #:	**GROUP #:**
PATIENT'S RELATIONSHIP TO PRIMARY CARD HOLDER:	**PRIMARY CARD HOLDERS NAME:**
PRIMARY CARD HOLDERS DATE OF BIRTH:	**PRIMARY CARD HOLDER SOCIAL SECURITY #:**
INSURANCE MAILING ADDRESS:	**INSURANCE PHONE #:**

SECONDARY INSURANCE TYPE:	
MEMBER ID #:	**GROUP #:**
PATIENT'S RELATIONSHIP TO PRIMARY CARD HOLDER:	**PRIMARY CARD HOLDERS NAME:**
PRIMARY CARD HOLDERS DATE OF BIRTH:	**PRIMARY CARD HOLDER SOCIAL SECURITY #:**
INSURANCE MAILING ADDRESS:	**INSURANCE PHONE #:**

ASSIGNMENT OF BENEFITS (Medicare/Private Patients):

I authorize payment of medical benefits directly to Howard Liss, MD Rehabilitation Institute, for services described. I accept full responsibility for total amount of bill.

Signature ____ Date ______________________________________

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administrations or their intermediaries or carries, or to the billing agent of this physician, any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in the place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature ____ Date ______________________________________

APPOINTMENT POLICY: Your appointment is reserved exclusively for you. Please be on time for your appointments. AS a courtesy to those patients waiting for appointments, 24-hour notice is required to cancel your appointment. Failure to adhere to this policy may result in a $50.00 charge.

PRIVATE INSURANCE: If provided with your insurance information and copy of your insurance card, we will process the claim for you and provide all the necessary paperwork to accompany your claim. If your insurance company is slow to pay or denies the claim, it is your responsibility to follow up with them, or you will be responsible for the bill. HOWEVER, YOU ARE RESPONSIBLE FOR YOUR CO-PAYMENT, CO-INSURANCE, AND ANY DEDUCTIBLE AT THE TIME OF SERVICE AND/OR ANY REMAINING BALANCE NOT COVERED BY YOUR INSURANCE.

MEDICARE: We will submit your claim to Medicare. We accept Medicare assignment; therefore, payment will come directly to us. However, you are still responsible for the 20% co-pay of what Medicare approves. If you have a secondary insurer, please be sure to provide us with a copy of your insurance card so we can submit to your secondary carrier.

Signature ____ Date ______________________________________

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INSURANCE INFORMATION

MOTOR VEHICLE ACCIDENT/ WORKERS' COMPNSATION ONLY

MVA: WORKERS' COMPENSATION:	**DATE OF ACCIDENT:**	**NJ CLAIM NY CLAIM**
NAME OF INSURANCE COMPANY:	**BODY PART(S) INJURED:**	
CLAIM #:		
MEDICAL ADJUSTER NAME:	**MEDICAL ADJUSTER DIRECT PHONE #:**	
MEDICAL ADJUSTER EMAIL:	**MEDICAL ADJUSTER FAX NUMBER:**	
(Work. Comp.) EMPLOYER AT TIME OF INJURY:		
ATTORNEY'S NAME:	**ATTORNEY'S PHONE #:**	
ATTORNEY'S ADDRESS:		

Have you filled out & returned your PIP application? **YES** **NO**
Has your employer filed an accident report? **YES** **NO**

NO-FAULT INSURANCE: If your claim was verified prior to your appointment, we will submit the bill to your insurance carrier in lieu of payment at time of service. We expect you to promptly complete and mail to your insurance carrier your PIP form and any other necessary paperwork needed by the carrier to process your claim. YOU WILL BE RESPONSIBLE FOR ANY DEDUCTIBLE, CO-PAYMENT, OR CO-INSURANCE. If you have a secondary insurance to cover this balance, it is up to you to file the claim.

WORKER'S COMPENSATION: If you are being seen due to a work-related injury, we will file with your compensation carrier. We expect you to provide us with the complete information to properly process your claim. If the insurance carrier denies the claim, you are responsible for the outstanding balance.

Signature ____________________ Date ____________________

MEDICAL INFORMATION RELEASE FORM (HIPAA)

RELEASE OF INFORMATION

I authorize the release of information including diagnoses, records, examination rendered to me, and claims information: This information may be released to the following individuals:

Spouse ____________________

Children ____________________

Other ____________________

Information is not to be released to anyone.

*This Release of Information will remain in effect until terminated by me in writing.

Signature ____________________ Date ____________________

PHONE MESSAGES

PLEASE CALL MY: Home Phone ____________ Cell Phone ____________ Work Phone ____________

IF UNABLE TO REACH ME:

Leave a detailed message Please ask me to return your call Other: ____________________

Signature ____________________ Date ____________________

HIPPA NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE 1.4.2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review carefully.

1. We may use or disclose your health information for purposes of treatment, payment, or healthcare operations without obtaining prior authorization. Here is one example for each:
    a. We may provide your health information to health care professionals including doctors, nurses, and technicians for purposes of providing you with care.
    b. Our billing department may access your information and send relevant parts to insurance companies to allow us to be paid for services we rendered to you.
    c. We may access or send information to our attorneys accountants in the event we need the information in order to address one of our business functions.
2. We may also use or disclose your health information under the following circumstances with our obtaining prior authorization.
    a. To notify and/or communicate with your family: unless you tell us you object, we may use or disclose your health information in order to notify your family or assist in notifying your family, personal representative or another person responsible for your care, about your location, your general condition in the event of your death. If you are unable or unavailable to agree or object, our health professional will use their best judgment in any communications with your family or others.

As required by law:

For public health purposes: we may use or disclose your health information to provide information to state of federal public health authorities, as required by law to prevent or control disease, injury or disability; to report child abuse or neglect; report domestic violence; report to the Food and Drug Administration problems with products and reactions to medications; and report disease or infection exposure. For health oversight activities: we may use or disclose your health information to health agencies during the course of audits, investigations, certifications, and other proceedings.

In response to the subpoenas or for judicial and the administrative proceedings: we may use or disclose your health information in the course of any administrative or judicial proceedings. However, in general we will attempt to ensure that you have been made aware of the use or disclosure of your health information.

To law enforcement personnel: we may use or disclose your health information to law enforcement official to identify or locate a subject, fugitive, material witness, or missing person, comply with a court order or subpoena and other law enforcement purposes.

To coroners or funeral directors: We may use or disclose your health information for purposes of communicating with coroners, medical examiners, and funeral directors.

For purposes of organ donation: We may use or disclose your health information for purposes of communication to organizations involved in procuring, banking, or transplanting organs and tissues.

For more information or to file the written, you may contact our Privacy Officer at the following address:

Howard Liss MD Rehabilitation Institute
Attn HIPPA Privacy Officer
111 Dean Drive, Suite 1 North
Tenafly, NJ 07670
Tel: (201) 390-9200
Fax: (201) 871-2214

For more information about HIPPA or to file a complaint:

Secretary of Health and Human Services
The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, DC, 20201
(202) 619-0257 or (877) 696-6775