NAME ________________________ DATE _____________

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or **No.**

Please explain any Yes answers in space provided.

Constitutional Symptoms		
Fever	**Y**	**N**
Chills	**Y**	**N**
Headache	**Y**	**N**
Other		

Eyes		
Blurred vision	**Y**	**N**
Double vision	**Y**	**N**
Pain	**Y**	**N**
Other		

Allergic /Immunologic		
Hay Fever	**Y**	**N**
Drug allergies	**Y**	**N**
Other		

Neurological		
Tremors	**Y**	**N**
Dizzy spells	**Y**	**N**
Numbness/tingling	**Y**	**N**
Other		

Endocrine		
Excessive thirst	**Y**	**N**
Too hot/cold	**Y**	**N**
Tired/sluggish	**Y**	**N**
Other		

Gastrointestinal		
Abdominal pain	**Y**	**N**
Nausea/vomiting	**Y**	**N**
Indigestion/heartburn	**Y**	**N**
Other		

Cardiovascular		
Chest pain	**Y**	**N**
Varicose veins	**Y**	**N**
High blood pressure	**Y**	**N**
Other		

Integumentary		
Skin rash	**Y**	**N**
Boils	**Y**	**N**
Persistent itch	**Y**	**N**
Other		

Musculoskeletal		
Joint pain	**Y**	**N**
Neck pain	**Y**	**N**
Back pain	**Y**	**N**
Other		

Ear/Nose/Throat/Mouth		
Ear infection	**Y**	**N**
Sore throat	**Y**	**N**
Sinus problems	**Y**	**N**
Other		

Genitourinary		
Urine retention	**Y**	**N**
Painful urination	**Y**	**N**
Urinary frequency	**Y**	**N**
Other		

Respiratory		
Wheezing	**Y**	**N**
Frequent cough	**Y**	**N**
Shortness of breath	**Y**	**N**
Other		

Hematologic/Lymphatic		
Swollen glands	**Y**	**N**
Blood clotting problem	**Y**	**N**
Other		

Psychological		
Are you generally satisfied with your life?	**Y**	**N**
Do you feel severely depressed?	**Y**	**N**
Have you considered suicide?	**Y**	**N**
Other		

Physician use only: (Comments/Notes)

BP:

P:

WT:

Orly Avitzur, M.D., M.B.A.

55 South Broadway
Tarrytown, NY 10591

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Fax (914) 631-0402

Diplomate in Neurology American Board of Psychiatry and Neurology

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TELEHEALTH CONSENT

READ **TELEHEALTH TERMS & CONDITION** ENTIRELY AT:

http://www.dravitzur.com/telehealth-consent

I, _________________________________, have read and agree to Tele-visit Terms & Conditions.

Signature: ____ Date:___________________

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Tarrytown, NY 10591

PATIENT REGISTRATION FORM

PLEASE ANSWER ALL QUESTIONS AND PRINT CLEARLY, THANK YOU DATE______________________

REASON FOR VISIT____

Patient Name ______________________________ Age __________ Sex __________
Last Name, First Name, Middle Initial

Address______________________________City __________State______Zip__________

Home Tel________________Cell ________________ Work Tel______________

Language ______________
Birthdate ________ Marital Status __________ HT WT Race ______________
Ethnicity ______________
Email address: ______________________________

Tobacco Y N Quit # of years smoking ________ packs/day ________ # of years quit ________

Referred by ______________Primary doctor________________ Tel ______________
TESTS: (including CTs, MRIs, X-rays) ______________________________
Previous neurologist/orthopedist or other? ______________________________

INSURANCE: ______________________________

Policyholder/relationship.________________DOB ________ Insurance referral required? Y N

Policyholder employer______________ Insurance member ID#______________________

Address______________________________City__________State___ Zip______Tel__________

Worker's Compensation/No-Fault: INSURANCE Name __________ Claim# __________WCB # ________

Address ______________________________City__________State Zip______Tel__________

Date of Injury:__________Are you working Y N

Claim Rep Name,________________ Claim Rep Tel:______________________

Employer Name________________ Address: City__________State ___Zip______Tel__________

List all Medications That You Take

Name	Milligrams/pill	Times per day
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________

Allergies____

Pharmacy Name________________Location________________Telephone____________________

Address__________________________City__________State__ Zip______Tel__________

List of hospitalization reason ____________________________Date ____________________________

Surgical History (Include years and specific name of surgery):

ASSIGNMENT OF BENEFITS SO THAT WE MAY FACILITATE PROCESSING OF ANY INSURANCE CLAIM FOR YOU

I hereby assign to you, my doctor, all medical and surgical benefits to what I am entitled, including Medicare, Private Insurance and any other insurance plan.
I hereby authorize said assignee to release all information necessary to process this claim.
I understand that I am financially responsible for all charges whether or not paid by said insurance, including any deductibles and copays, and that payments are due at the time services are rendered.

I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Signed:____Date_______________________

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No-show policy

Cancellations with less than 24 hours notice are subject to a late cancellation fee ($25 for a follow-up appointment and $50 for a new patient or an electromyography (EMG) appointment).

Signed______________________________

Date_ _

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _ _ _ _ _ _ _ _ _ _ have reviewed a copy of ORLY AVITZUR, MD, PC's Notice of Privacy Practices.

______________________________ Signature of Patient

____________________ Date