FORM A

☐ Lenox Hill Hospital - SURGICAL CASES FAX TO: 866-219-5545

☐ Manhattan Eye, Ear & Throat Hospital - SURGICAL CASES FAX TO: 866-231-1027

Date of Surgery: ______ / ______ / ______

Physician's Name: ____________________

PATIENT INFORMATION

Name: Last ____________________ First ____________________

Address: Street ____________________ City ______ Apt # ______ State ______ Zip ______

County Of Residence: ____________________ Phone ( ) ______ S.S. # ___ — ___ — ___

RACE:
☐ Asian ☐ Black ☐ White
☐ Hispanic ☐ American Indian

SEX: ☐ Male ☐ Female

MARITAL STATUS:
☐ Married ☐ Widowed
☐ Single ☐ Divorced
☐ Separated

DATE OF BIRTH
Month | Day | Year

Mother's Maiden Name

Patient's Maiden Name

Place of Birth

Are you an Employee of LHH / MEETH? ☐ Yes ☐ No

Religion

Advance Directives:
☐ Yes (Provide Copy) ☐ No
Type: ☐ Healthcare Proxy
☐ Living Will
☐ Do Not Resuscitate
☐ Other: ____________________ Specify

Do You Carry An Organ Donors Card? ☐ Yes ☐ No

Occupation

Employer

Employer Address
Street
City State Zip

Length of Service With Current Employer — Years | Months

Employer's Phone ( )

EMPLOYMENT STATUS
☐ Employed ☐ Disabled
☐ Unemployed ☐ Retired

ACCIDENT INFORMATION

IF THIS ADMISSION IS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THIS SECTION IN FULL

Type of Accident: ☐ Work Related ☐ Auto ☐ Home ☐ School ☐ Other **Date of Accident:** Month | Day | Year

Time of Accident: ☐ AM ☐ PM **Location of Accident:** Street City State Zip

PERSON RESPONSIBLE FOR FINANCIAL ARRANGEMENTS

Name of Person on Insurance Card Last First **Relationship to Patient**

Name Last First

Address Street Apt # City Zip

County of Residence | **Phone # ( )** | **Social Security #** ___ — ___ — ___

Employment Status ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired | **Sex** ☐ Male ☐ Female | **Birth Date**

Occupation | **Employer**

Employer Address Street City State Zip | **Phone ( )** **Ext:**

PERSON TO CONTACT IN AN EMERGENCY

Relationship to Patient ____________________

Name: Last First **Address:** Street City Apt # State Zip

Home Phone: ( ) Work Phone: ( ) Ext:

IF PATIENT IS 18 OR UNDER (25 IF STUDENT) ENTER OTHER PARENT INFORMATION BELOW.
IF PATIENT IS MARRIED ENTER SPOUSE INFORMATION. OTHERWISE ENTER CLOSEST RELATIVE.

LEGAL NEXT OF KIN

Relationship to Patient ____________________ **Date of Birth** ____________________

Name: Last First **Address:** Street City Apt # State Zip

Home Phone: ( ) Work Phone: ( ) Ext:

MISCELLANEOUS

Have you ever been an inpatient at Lenox Hill Hospital / MEETH? ☐ Yes ☐ No

If yes, under what name? ____________________ **Dates: From:** Mo | Dy | Yr **To:** Mo | Dy | Yr

Have you been an inpatient in another Hospital or Skilled Nursing Facility within the last 60 days? ☐ Yes ☐ No

If yes, under what name? ____________________ **Dates: From:** Mo | Dy | Yr **To:** Mo | Dy | Yr

Name of Institution: ____________________

FORM B

☐ Lenox Hill Hospital - SURGICAL CASES FAX TO: 866-219-5545

☐ Manhattan Eye, Ear & Throat Hospital - SURGICAL CASES FAX TO: 866-231-1027

Date of Surgery: ______ / ______ / ______

Physician's Name: ____________________

INSURANCE INFORMATION PLEASE COMPLETE THE APPROPRIATE SECTIONS BELOW FOR BOTH PATIENT AND SPOUSE, OR BOTH PARENTS IF PATIENT IS 21 OR UNDER . . . **AND ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARDS.**

MEDICARE

MEDICARE HEALTH INSURANCE

SOCIAL SECURITY ACT

Name of Beneficiary

Claim Number Sex

Is Entitled To Effective Date

Hospital (Part A)

Hospital (Part B)

MEDICARE PATIENTS OR SPOUSE

ARE YOU RETIRED? ☐ YES ☐ NO

IS YOUR SPOUSE RETIRED? ☐ YES ☐ NO

DATE OF RETIREMENT PATIENT

SPOUSE

OTHER BLUE CROSS

BLUE CROSS/BLUE SHIELD OF ____________________ STATE

SUBSCRIBER'S NAME ____________________

IDENTIFICATION ____________________

DO YOU HAVE OTHER INSURANCE? ☐ YES ☐ NO

IF SPOUSE IS EMPLOYED, PLEASE PROVIDE HIS/HER INSURANCE INFORMATION ON THIS FORM.

OTHER INSURANCE (HMO, UNION, TRAVELERS, METROPOLITAN, ETC.)

Name on Card LAST ______ FIRST ______

Policy Number ID # ______ GRP # ______

Payor ID Number ____________________

Group Name ____________________

• Employer Name ____________________ AS IT APPEARS ON THE CARD

Address ____________________

____________________ Phone ______

Insurance Company Name ____________________

Address ____________________

____________________ Phone ______

WORKERS COMP (ATTACH AUTHORIZATION FORM)

INSURANCE COMPANY NAME ______ ADDRESS ______ PHONE (   ) ______ - ______

EMPLOYER NAME ______ ADDRESS ______ PHONE (   ) ______ - ______

WCB # ______ Accident Date ______ / ______ / ______ Accident Time ______ ☐ AM ☐ PM Claim Filed: ☐ Yes ☐ No

NO FAULT (ATTACH FORM FROM INSURANCE COMPANY)

INSURANCE COMPANY NAME ______ ADDRESS ______ PHONE (   ) ______ - ______

CAR OWNER NAME ______ ADDRESS ______ PHONE (   ) ______ - ______

INSURANCE AGENT OR ATTORNEY NAME ______ PHONE (   ) ______ - ______

ACCIDENT DATE ______ / ______ / ______ Accident Time ______ ☐ AM ☐ PM POLICY NO. ______ FILE NO. ______

MEDICAID

NAME ON CARD LAST ______ FIRST ______

ID NUMBER ____________________

ISO # ______ ACCESS NUMBER ______ SEQ # ______

☐ **SELF PAY/UNINSURED**

FORM C

Manhattan Eye, Ear & Throat Hospital

PATIENT QUESTIONNAIRE

Patient Name:

Planned procedure:

____

Please list ALL PAST SURGERIES:

____

____

____

ANESTHESIA problems: ☐ Yes ☐ No

If Yes, please list:

____

Please list ALL MEDICATIONS, including DOSAGE :

____

____

____

____

____

____

List any ALLERGIES (medications/food/inhalant):

____

____

Do you smoke? ☐ Yes ☐ No

Did you previously smoke? ☐ Yes ☐ No

Packs per day:________ for ________ years Quit________

Do you drink alcohol? ☐ Yes ☐ No

Number of drinks per week ________

Do you use recreational drugs? ☐ Yes ☐ No

Please List ______________ How often________

Please list any non-prescription medications:
(e.g. cold tablets, vitamins)

____

____

Please list any HERBAL:
(e.g. Cava-Cava, Ginkgo, Ginseng, St. John's wort, Echinacea)

____

____

Surgeon:

Please check any symptoms you have recently experienced:

☐ Fever / chills ☐ Weight loss
☐ Weakness ☐ Fatigue
☐ Pain (identify location):______________________

Please list ALL YOUR medical conditions:

☐ Anxiety	☐ Kidney disease
☐ Arthritis	☐ Liver disease
☐ Asthma	☐ Pacemaker
☐ Bleeding problems	☐ Palpitations/irregular heart
☐ Bronchitis	☐ Pneumonia
☐ Chest pain	☐ Reflux
☐ COPD	☐ Seizure
☐ Depression	☐ Shortness of breath
☐ Diabetes	☐ Sickle cell
☐ Excessive bruising	☐ Sleep apnea
☐ Glaucoma	☐ Stroke
☐ Heart Attack	☐ TB
☐ Heat/Cold problems	☐ Thyroid disease
☐ Hiatal hernia	☐ Ulcer
☐ High blood pressure	☐ Urinary problems

Family History of Medical Conditions:

☐ Asthma	☐ Heart
☐ Cancer	☐ High blood pressure
☐ Diabetes	☐ Stroke
☐ Emphysema	☐ Other:__________

List your primary care physician:

Name:______________________________

Address:______________________________

____

Telephone:______________________________

Date:______________ Patient Signature:______________________________

Fax to (866) 231-1027