NYU Langone
MEDICAL CENTER

PATRICK A. MEERE, M.D.
530 First Avenue, Suite 5J
New York, New York 10016
T 212.263.2366 • F 212.263.2365
info@drpatrickmeere.com • www.drpatrickmeere.com

WELCOME

We are pleased to welcome you to our office.

Date: _____ /_____ /_____

Dear _____,

Your appointment is scheduled for _____

You may require an X-Ray prior to your visit with Dr. Meere and we have made that appointment for you at the Faculty Practice Radiology Office at

_____

In order to help your evaluation proceed smoothly, please review the enclosed material prior to arriving in our office. Please complete as much information on the forms as possible, as this will assist Dr. Meere greatly in your evaluation.

Please find attached the following forms for your completion:

- Patient Registration
- Patient Medical History
- Office Financial Policy and Office Policy Form
- Knee/Hip Functional Score Forms

Please remember to bring the following with you at the time of your appointment:

- Completed forms
- Insurance card and photo I.D.
- Medical Records, X-Rays, MRIs, operative reports and lab results from other facilities
- Comfortable, loose-fitting clothing, including gym shorts, sweat pants
- Directions

Enclosed please find a card with the date and time of your appointments. Directions to our office and the Faculty Practice Radiology Office are also enclosed.

The office will call you 24-48 hours prior to your appointment to confirm and will need to speak to you or your representative in person for final confirmation. Please note that if you can not keep your appointment we appreciate that you notify us at least 24 hours in advance.

If you would like more information on Dr. Meere and his orthopeadic specialty please visit his website at **www.drpatrickmeere.com**

We look forward to seeing you at your scheduled appointment.

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PATIENT REGISTRATION FORM

Patient's Name _____ M.I. _____ Date of Birth: _____/_____/_____

Insured's Social Security # _____ Age ____ Sex: ◯ Male ◯ Female Marital Status: S M W D

Full Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Email: _____

Employer: _____ Address: _____

Occupation: _____ Work #: _____ Retired: ◯ Yes ◯ No

Primary Care Physician: Name: _____ Phone: _____

Who may we thank for referring you to us (If Medical Doctor please provide the telephone number)? _____

_____

Pharmacy: Name: _____ Phone: _____

Address: _____

INSURANCE INFORMATION-PRIMARY *If you are NOT the policy holder please provide the Guarantor's information*

Insurance Company: _____ Policy #: _____ Group/Plan#: _____

Name of Guarantor: _____ Relationship: _____

Address of Guarantor's Employer: _____ Work #: _____

Insured's Social Security # _____ Insured's Date of Birth: _____/_____/_____

SECONDARY INSURANCE

Insurance Company: _____ Policy #: _____ Group/Plan#: _____

Name of Guarantor: _____ Relationship: _____

IN CASE OF EMERGENCY *I herewith authorize the following 2 persons to be able to access my health care information and be contacted in case of an emergency:*

Name: _____ Relationship: _____

Home #: _____ Cell #: _____ Other: _____

Name: _____ Relationship: _____

Home #: _____ Cell #: _____ Other: _____

ASSIGNMENT

I hereby certify that the statements and information in the registration package are true and correct to the best of my knowledge and belief.

Signature of Responsible Party/Patient: _____ Date: _____/_____/_____

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PATIENT MEDICAL HISTORY

Patient's Name: _____ M.I. ____ Date of Birth: ____/____/____

Metrics: Height _____ Weight _____ BMI _____

CHIEF COMPLAINT: reason for visit — DETAILS

_____ Duration of Symptoms: _____

MEDICATIONS: name and dosage if known — DETAILS

Allergies: medications, foods, drugs, seasonal _____

Adverse Reaction to Anesthesia: Ⓨ Ⓝ _____

Anticoagulation: Are you currently on any of the following medications? Ⓨ Ⓝ

◯ Coumadin/Xarleto/Rivaroxaban ◯ Aspirin or Ecotrin ◯ Platelet Inhibitor (eg Plavix) ◯ Vitamin E

FAMILY HISTORY: — DETAILS

Cardiac Disease: Ⓨ Ⓝ _____

Cancer: Ⓨ Ⓝ _____

Inflammatory Disease: Ⓨ Ⓝ _____

Other: Ⓨ Ⓝ _____

SOCIAL HISTORY: — DETAILS

Alcohol Use: Ⓨ Ⓝ _____

Tobacco Smoking: Ⓨ Ⓝ _____

Substance Abuse: Ⓨ Ⓝ _____

PAST SURGICAL HISTORY: — YEAR / SURGERY / HOSPITAL / DETAILS

Reviewed by: _____ Date: ____/____/____
Patrick A. Meere, MD

Patient's Name: _____ M.I. ____ Date of Birth: ____/____/____

REVIEW OF SYSTEMS:

GENERAL:
Unexplained weight loss: Y N _____
Fevers I chills I sweats: Y N _____
Chronic fatigue: Y N _____

CARDIOVASCULAR:
Heart disease: Y N _____
Previous heart attack: Y N _____
Pacemaker/defibrillator: Y N _____
High Blood Pressure: Y N _____
Poor circulation: Y N _____
Previous leg clots: Y N _____

PULMONARY:
Asthma: Y N _____
COPD: Y N _____
Shortness of breath: Y N _____
Pulmonary Embolus: Y N _____

RENAL:
Renal failure: Y N _____
Dialysis: Y N _____

HEMATOLOGICAL:
Bleeding disorder: Y N _____
Sickle cell disease: Y N _____
Gaucher's disease: Y N _____

ENDOCRINE:
Diabetes: Y N _____
Thyroid Disease: Y N _____

NEUROLOGIC:
Migraines: Y N _____
Epilepsy: Y N _____
Parkinson's disease: Y N _____
Chronic neuropathy: Y N _____
Spinal stenosis: Y N _____

GASTROINTESTINAL:
Peptic ulcer: Y N _____
Diverticulitis: Y N _____
Inflamed Bowel dis.: Y N _____

GENITOURINARY:
Incontinence: Y N _____
Prostate disease: Y N _____

DERMATOLOGIC:
Psoriasis: Y N _____
Chronic cellulitis: Y N _____

ENT:
Deafness: Y N _____
Chronic sinusitis: Y N _____

OPHTHALMIC:
Cataracts: Y N _____
Glaucoma: Y N _____
Retinal disease: Y N _____

PSYCHIATRIC:
Anxiety disorder: Y N _____
Insomnia: Y N _____
Affective disorder: Y N _____
Chronic depression: Y N _____

MUSCULOSKELETAL:
Rheumatoid arthritis: Y N _____
Lupus: Y N _____
Lyme disease: Y N _____
Osteoarthritis: Y N _____
Joint replacements: Y N _____

ONCOLOGICAL:
Cancer Type: _____
Cancer Type: _____
Cancer Type: _____

ADDITIONAL CONDITION[S] / COMMENTS:

_____

_____

_____

_____

_____

_____

_____

Reviewed by: _____ Date: ____/____/____

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DR. PATRICK MEERE'S FINANCIAL POLICY AND OFFICE POLICY

1. RELEASE OF INFORMATION: I Authorize Dr. Patrick Meere to use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

2. FINANCIAL LIABILITY: I hereby authorize payment directly to Dr. Patrick Meere. I understand that I am financially responsible for all charges whether or not covered by insurance, for all services tendered on my behalf or my dependents. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

3. ASSIGNMENTS OF BENEFITS — PRIVATE AND FEDERAL (Medicare): I authorize payments of medical and surgical benefits, including Medicare benefits, to be made either to me or on my behalf to Dr. Patrick Meere for any services furnished by my physician to me. As Dr. Patrick Meere is a non-participating Medicare provider, the office reserves the right not to accept assignment. As such full payment is due at the time of service based on the current non-participating Medicare fee schedule.

4. LITIGATION DISCLAIMER: It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that Dr. Patrick Meere reserves the right not to participate in any way in litigation except to provide a true and accurate copy of any medical record in the possession and control of this office, pursuant to receipt of a properly notarized consent for medical information, requested by the patient or his/her legal guardian, and upon payment of the usual fee.

5. RADIOLOGICAL FILMS: Radiology films are the property of the patient. Dr. Patrick Meere will release films only to the patient or representative of the patient, should the office be in possession of the X-Ray film.

6. CREDIT CARD PAYMENTS: I acknowledge that Dr. Patrick Meere will retain the right to impose a surcharge on credit cards that is no greater than our cost of acceptance for transactions greater than $1000.

7. CANCELED OR NO-SHOW APPOINTMENT/SURGERY: I understand that I may incur a cancellation fee if I do not provide sufficient notice of cancellation, for non-medical reasons: 24 hours for appointments, 7 days for surgeries.

I have read the above conditions of treatment and payment and agree to their content.

Patient/Guarantor Signature: _____ Date: _____/_____/_____
Signature

Patient/Guarantor Name: _____
Please Print

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RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that on _____ I received The Notice of Privacy Practices from Patrick A. Meere MD PC, which sets forth the ways in which my personal health information may be used or disclosed by the office of Patrick A. Meere MD PC, and outlines my rights with respect to such information.

_____ Date: _____/_____/_____
Signature

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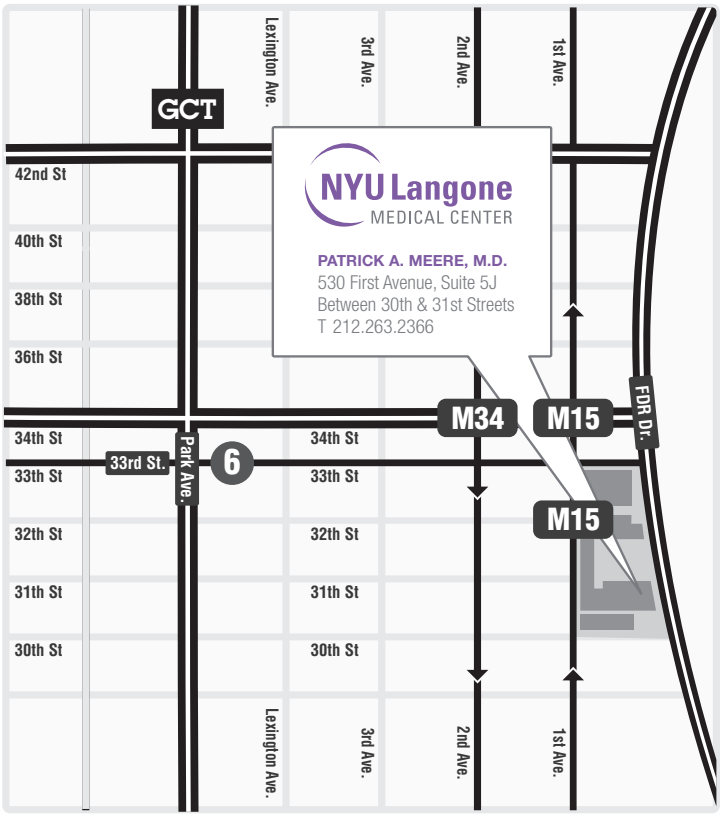
DIRECTIONS

To our office: Our office is part of the NYU Langone Medical Center located at 530 First Avenue between 30th and 34th Street. Please enter through the main hospital entrance on First Avenue. You may be asked to present a piece of identifican to a security guard. Then follow the signs for the Green pathway and take the Schwartz elevator East to the 5th floor. Our office is located in front of the elevators in 5J.

By Bus:

- The **M15** bus runs the length of First and Second Avenues. When heading uptown the bus stops directly in front of the NYU Langone Medical Center. When heading downtown exit at Second Avenue and walk one block east to the NYU Langone Medical Center.

- The **M34** or **M34A** bus runs the length of 34th Street. Exit at Second Avenue and 34th Street and walk one block east then south on First Avenue for the NYU Langone Medical Center.



By Subway/Rail :

- **Number 6 subway** stops at 33rd Street and Park Avenue and is walking distance (0.6 mi/12 min.)
- **Number 4, 5 & 6 subways and Metro North RR** at Grand Central Terminal (GCT)

Parking:

Available in the garage at the NYU Langone Medical Center (near the corner of 30th Street) and across the street at Rapid Park

Directions to the Faculty Practice Radiology Department:

The NYU Faculty Practice Radiology Department is located within the NYU Langone Medical Center. After passing the security guard at the main entrance follow the signs for the Green pathway to the Schwartz Elevator West to the 2nd floor. We will notify the Radiology department of your visit and send a prescription ahead of time. After you have had your X-Rays taken, please proceed down the hall to the Schwartz Elevator East and take it to the 5th floor.

For information, including additional directions, parking, hospital maps and places to stay visit **http://www.med.nyu.edu/directions-parking**

We look forward to seeing you at your scheduled appointment.