Bennie W. Chiles III, MD, FAANS, FACS
Board Certified, American Board of Neurological Surgery
Fellow, American College of Surgeons

280 North Central Avenue, Suite 235 Hartsdale, NY 10530
Tel. (914)332-0396 Fax (914)468-8895

Bennie W. Chiles III, M.D., F.A.C.S.
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Fellow, American College of Surgeons

Dear Patient,

Your neurosurgical consultation appointment has been made with our office. Please follow the instructions below in order to make your visit with us as productive as possible.

1. Complete registration forms and bring with you on the day of your appointment.
2. Bring one form of photo identification.
3. **YOU MUST BRING YOUR MRI OR CT SCAN FILMS / DISC ALONG WITH THE WRITTEN REPORT (if report not previously provided)**.

The Surgeon is unable to make a complete diagnosis or properly recommend the appropriate treatment without viewing the films or C.D.'s and reports. It is necessary that you bring a "hard" copy of your MRI/CT Scan with you to your appointment. If you do not bring the films/disc, your appointment will be rescheduled.

INSURANCE:

1. Your insurance identification card will be necessary.
2. If your insurance requires a co-payment you will be responsible that copay amount at the time of your appointment.
3. For Workers' Compensation, complete insurance related forms in its entirety.

DIRECTIONS

1. If not enclosed, you may obtain directions to the office on our website at www.wsbsonline.com.
2. If travelling by GPS and "North Central Avenue" is not showing, you can use "Route 100" or "Central Park Avenue".
3. Public Transportation; Bee Line Bus #20. Hartsdale Train Station 1.2 miles south of office. White Plains Train Station 1.2 miles north of office.

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

Due to the nature of this practice, if an emergency arises it may be necessary to cancel or reschedule patient appointments.

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Visit Date: _______________

Patient Name: ____
First Middle Last

Reason for visit:____

Sex (M/F/T): ____ Age: ___ Birthdate: __________ SS#: ___________________ Marital Status: ______

Mailing address: ____

City: _______________________State: ______Zip: _________ Driver's license#/State:______________

Phone numbers: _____________________ _______________________ _______________________
Home **Work** **Cell**

Email address: ______________________________________

Employer: ____

____
Address City State Zip

Referring Physician

Name: ______________________________

Address: ____________________________

City/State/Zip: _______________________

Phone #: ___________________________

Primary Care Physician

Name: __________________________

Address: _________________________

City/State/Zip: ____________________

Phone #: _________________________

Emergency contact ____
Name Daytime Phone number Relationship to patient

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Participating Disclosure Form

Bennie W. Chiles III, M.D. is participating provider with the following Healthcare Plans:

MVP Health Care (in network with Essentials HMO and Medicaid Managed Plans ONLY)
Workers' Compensation (except Dept. of Labor, non-participating)
Automobile "No Fault" Insurance

Bennie W. Chiles III, M.D. is affiliated with the following Hospitals:

White Plains Hospital Center
Montefiore Hospital New Rochelle
Westchester Medical Center
St. John's Riverside Hospital
St. John's Riverside Hospital - Dobbs Ferry Pavilion
Stamford Hospital
New York- Presbyterian Westchester

Acknowledgement of Receipt:

Print name: ____

Signature: ____

Date: ______________

Representative, if signing for patient:

Print Name: ____

Signature: ____ Date: ________________

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Acknowledgement of Receipt of Westchester Spine and Brain Surgery, PLLC Privacy Practices

FOR FURTHER INFORMATION, PLEASE SEE THE COMPLIANCE OFFICER

I hereby acknowledge that Westchester Spine and Brain Surgery, PLLC's, Notice of Privacy Practices was explained to me, and a written copy will be provided at my request. I further acknowledge and understand that if I have any questions about Westchester Spine and Brain Surgery, PLLC's privacy practices or my rights with regard to my personal health information, I may contact the privacy officer for further information as set forth in this notice.

________________________________ ________________________________
Name of Patient – please print name (Name of Representative if applicable)

________________________________ ________________________________
Signature of Patient or Representative Date of signature

____
If signed by Representative, state the representative's authority to act on behalf of patient.

DOCUMENTION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:____________________________________ Patient I.D. #____________________________

I hereby certify that on ____/____/____(MM/DD/YR), I made a good faith effort to obtain the above patients written acknowledgement of receipt of Westchester Spine and Brain Surgery, but was unable to do so for the following reason(s).

____

____
Name of Staff Personnel

____
Signature of Staff Personnel

Please take note: This document will be maintained permanently in the patients medical record or other file on premises.

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Pharmacy

Pharmacy name: ________________________________ Store# if applicable: ______________

Address: ____

City: _______________________________ State: _______________ Zip code: _____________

Telephone: (______) ______________________ Fax: (______) ________________________

Our office complies with the NYS e-prescribe program. As a component of electronic prescribing, we require your consent to access your medication history from your pharmacy and/or the NYS Health Commerce System.

Patient Signature: _______________________________________ Date: ________________

Private Health Insurance Information

Insurance Company: ____

I.D. #: _________________________________

Group Name: ___________________________ Group #: _______________________________

Policy Holder information if different from the Patient:

Name: __________________________________ Date of Birth: ___________________________

Relation to patient: _______________________ Social Security #: ________________________

Address & Telephone (**if different from patient**): ______________________________________

____

Employer, Address & Telephone (for policy holder): ____________________________________

____

PLEASE INFORM THE OFFICE STAFF OF ANY SECONDARY OR TERTIARY INSURANCE

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Medical/Social History

Are there any serious medical problems that run in your family? Y_______ N_______

If Yes, please list: ____

List any prior major illness and/or injuries: ____

Right or Left Handed? _________Approximate Height? __________ Approximate Weight? _________

Smoker? ________ If Yes, How Much? ________Do You Drink? _______ If So, How Often? ________

Medical Marijuana use? YES NO
Circle one

Recreational Drug use? YES NO
Circle one

SURGICAL PROCEDURES	YEAR	COMPLICATIONS?

CURRENT MEDICATIONS	DOSE	FREQUENCY

LIST ALL ALLERGIES TO MEDICATION/MEDICAL MATERIAL (i.e., contrast dye, latex):
____

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

Patient Signature: ____Date: __________________