



Account #: \_\_\_\_\_

Date: \_\_\_\_\_ Physician: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ Phone: [ ] Home: \_\_\_\_\_  
 First: \_\_\_\_\_ MI: \_\_\_\_\_ [ ] Work: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ [ ] Cell: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ PLEASE CHECK PHONE YOU WISH TO BE REACHED.  
 Employer: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Marital Status: [ ] Married [ ] Single [ ] Other Spouse's Name: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**PRIMARY INSURANCE**

Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_ Claims Address: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ City: \_\_\_\_\_  
 SS#: \_\_\_\_\_ State: \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_ Claims Address: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ City: \_\_\_\_\_  
 SS#: \_\_\_\_\_ State: \_\_\_\_\_  
 DOB: \_\_\_\_\_

I authorize the release of any medical information necessary to process the claim(s) services rendered to me. I also authorize payment of medical benefits directly to Spine & Brain Neurosurgery Center, Inc. for services rendered to me. I understand that I will be responsible for all co-pays, deductibles and non-covered services as determined by my Insurance Carrier. I accept full responsibility for any outstanding balance with Spine and Brain Neurosurgery Center, Inc.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature of patient or authorized representative. If authorized representative, please state relationship to patient.

DO YOU HAVE LEGAL POWER OF ATTORNEY? [ ] YES [ ] NO. IF YES, PLEASE PROVIDE A COPY TO OUR OFFICE.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

**PATIENT HISTORY FORM, PAGE 1**

REFERRING PHYSICIAN: \_\_\_\_\_ PRIMARY CARE PHYSICIAN: \_\_\_\_\_

RIGHT \_\_\_\_\_ OR LEFT \_\_\_\_\_ HANDED. BIRTH PLACE/NATIONALITY: \_\_\_\_\_

EDUCATIONAL BACKGROUND: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

**LIST ALL SYMPTOMS OR COMPLAINTS RELATED TO TODAY'S VISIT:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:** MARITAL STATUS: \_\_\_\_\_ NUMBER OF CHILDREN: \_\_\_\_\_

DO YOU SMOKE: \_\_\_\_\_ HOW MUCH PER DAY: \_\_\_\_\_ NO. OF YEARS: \_\_\_\_\_ DO YOU USE DRUGS: \_\_\_\_\_

DO YOU DRINK ALCOHOL: \_\_\_\_\_ HOW MUCH: \_\_\_\_\_ HOW OFTEN: \_\_\_\_\_

**LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING OVER-THE-COUNTER MEDICATIONS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ARE YOU **ALLERGIC TO** :( IF YES, PLEASE LIST NAMES)

MEDICATIONS: \_\_\_\_\_

CONTRAST DYE : \_\_\_\_\_ OTHER: \_\_\_\_\_

HAVE YOU HAD ANY **PROCEDURES OR SURGERY** IN THE PAST: YES/NO IF YES PLEASE GIVE YEAR, TYPE OF SURGERY, SURGEON'S NAME, AND HOSPITAL NAME:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE **YOU BEEN HOSPITALIZED** FOR ANY PROBLEMS NOT MENTIONED ABOVE: \_\_\_\_ YES \_\_\_\_ NO

IF YES, PLEASE STATE REASON, YEAR AND HOSPITAL: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY:** LIST AGE, HEALTH CONDITION FOR EACH MEMBER OR AGE AT AND CAUSE OF DEATH

PARENTS: \_\_\_\_\_

\_\_\_\_\_  
BROTHERS/SISTERS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

**PATIENT HISTORY FORM, PAGE 2**

HAVE YOU EVER HAD ANY OF THE FOLLOWING: IF YES, PLEASE CHECK.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> MEASLES         | <input type="checkbox"/> DIFFICULTY WITH URINATION  | <input type="checkbox"/> LOW BLOOD PRESSURE   |
| <input type="checkbox"/> MUMP            | <input type="checkbox"/> DRIBBLE /BLOOD IN URINE    | <input type="checkbox"/> HIGH BLOOD PRESSURE  |
| <input type="checkbox"/> CHICKEN POX     | <input type="checkbox"/> FREQUENCY & BURN URINATING | <input type="checkbox"/> STROKES/HEART ATTACK |
| <input type="checkbox"/> DIPHTHERIA      | <input type="checkbox"/> KIDNEY AILMENTS OR STONES  | <input type="checkbox"/> HEART DISEASE        |
| <input type="checkbox"/> TUBERCULOSIS    | <input type="checkbox"/> HIGH CHOLESTEROL           | <input type="checkbox"/> ANEMIA               |
| <input type="checkbox"/> INFECTIOUS MONO | <input type="checkbox"/> ACCIDENT (DATE) _____      | <input type="checkbox"/> OTHER BLOOD DISEASE  |
| <input type="checkbox"/> ENCEPHALITIS    | <input type="checkbox"/> CONCUSSION                 | <input type="checkbox"/> SHORTNESS OF BREATH  |
| <input type="checkbox"/> POLIO           | <input type="checkbox"/> LOSS OF CONSCIOUSNESS      | <input type="checkbox"/> CHRONIC COUGH        |
| <input type="checkbox"/> MENINGITIS      | <input type="checkbox"/> EPILEPSY                   | <input type="checkbox"/> WHEEZING             |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> THYROID CONDITION          | <input type="checkbox"/> SPITTING UP OF BLOOD |
| <input type="checkbox"/> GONORRHEA       | <input type="checkbox"/> NERVOUS BREAKDOWN          | <input type="checkbox"/> NIGHT SWEATS         |
| <input type="checkbox"/> SYPHILIS        | <input type="checkbox"/> PSYCHIATRIC TREATMENT      | <input type="checkbox"/> DIZZINESS            |
| <input type="checkbox"/> ASTHMA          | <input type="checkbox"/> DRUG POISONING/OVERDOSE    | <input type="checkbox"/> PARALYSIS/WEAKNESS   |
| <input type="checkbox"/> EMPHYSEMA       | <input type="checkbox"/> EXPOSURE TO TOXINS         | <input type="checkbox"/> NUMBNESS             |
| <input type="checkbox"/> PNEUMONIA       | <input type="checkbox"/> EYE DISEASE                | <input type="checkbox"/> TINGLING             |
| <input type="checkbox"/> DIABETES        | <input type="checkbox"/> IMPAIRED SIGHT             | <input type="checkbox"/> CHEST PAIN           |
| <input type="checkbox"/> JAUNDICE        | <input type="checkbox"/> DOUBLE VISION              | <input type="checkbox"/> PALPITATIONS         |
| <input type="checkbox"/> HEPATITIS       | <input type="checkbox"/> HEARING PROBLEMS           | <input type="checkbox"/> SWELLING OF FEET     |
| <input type="checkbox"/> LIVER DISEASE   | <input type="checkbox"/> RINGING IN EARS            | <input type="checkbox"/> NAUSEA OR VOMITING   |
| <input type="checkbox"/> CANCER          | <input type="checkbox"/> FAINTING SPELLS            | <input type="checkbox"/> ULCER                |
| <input type="checkbox"/> NEURITIS        | <input type="checkbox"/> CONVULSIONS                | <input type="checkbox"/> STOMACH PAIN         |
| <input type="checkbox"/> ARTHRITIS       | <input type="checkbox"/> HEADACHES                  | <input type="checkbox"/> BLOOD IN STOOL       |

\*\*\*WOMEN ONLY: **ARE YOU PREGNANT?** \_\_\_ YES \_\_\_ NO

HAS ANY BLOOD RELATIVE EVER HAD: (IF YES, CHECK AND GIVE RELATIONSHIP)

- |  |            |
|--|------------|
| <input type="checkbox"/> (1) PARKINSON'S         | (1) _____  |
| <input type="checkbox"/> (2) TREMORS             | (2) _____  |
| <input type="checkbox"/> (3) DIABETES            | (3) _____  |
| <input type="checkbox"/> (4) MENTAL ILLNESS      | (4) _____  |
| <input type="checkbox"/> (5) TUBERCULOSIS        | (5) _____  |
| <input type="checkbox"/> (6) STROKE              | (6) _____  |
| <input type="checkbox"/> (7) EPILEPSY            | (7) _____  |
| <input type="checkbox"/> (8) HIGH BLOOD PRESSURE | (8) _____  |
| <input type="checkbox"/> (9) ANEMIA              | (9) _____  |
| <input type="checkbox"/> (10) ARTHRITIS          | (10) _____ |
| <input type="checkbox"/> (11) HEADACHES          | (11) _____ |
| <input type="checkbox"/> (12) HEART DISEASE      | (12) _____ |
| <input type="checkbox"/> (13) CANCER             | (13) _____ |
| <input type="checkbox"/> (14) KIDNEY PROBLEMS    | (14) _____ |

**PLEASE NOTE:**

**IN ORDER TO KEEP YOUR INFORMATION AS CURRENT AS POSSIBLE, PLEASE NOTIFY THE OFFICE OF ANY CHANGE IN MEDICATIONS OR MEDICAL HISTORY.**

By signing, you are stating that this form has been filled out with accurate information. Should any changes occur in your health, or insurance provider, or in any other aspect, it is your responsibility to notify our office.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Signature of patient or authorized representative. If authorized representative, please state relationship to patient.

REVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

ALL FIELDS MUST BE COMPLETED

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

DATE: \_\_\_\_\_

**POLICIES**

**FORM COMPLETION POLICY**

Spine & Brain Neurosurgery Center, Inc. charges for form completions. The first requested form from each patient will be completed at no charge. We will continue to help our patients to the best of our ability but have found the need to charge for completion of additional forms. Each additional form will be completed at a charge of \$10.00 per form. This charge will be payable by the patient requesting completion and will not be billed to any insurance company.

Requests will be completed in seven to ten business days and payment is due upon request of form completion.

**MEDICATION REFILL POLICY**

Please allow 2-3 business days for medication refills. Any request for refills after 3:00 p.m. will be addressed on the next business day. Refill requests received after hours, or on weekends and holidays, will be considered the following business day.

Workers Compensation cases may need to come into the office to pickup medication refills.

Please contact your pharmacy and request that they fax your refill request to our office.

**Do not wait until you are out of medication before your request is called in. Your doctor may not be available to approve your refill on an urgent basis.**

**MEDICAL RECORDS RELEASE POLICY**

You will need to sign a release form requesting our office to release your records to any other doctor or facility. If your attorney is requesting records they must submit a written request with your signed release attached to our records department. Please allow up to 10 business days for a request to be processed.

If you are requesting a copy of your records, please be aware that the cost is \$1.00 per page. Please allow up to 7 business days for your request to be processed.

**NO SHOW/CANCELLATION POLICY**

If it is necessary to cancel or reschedule your appointment, please do so at least 24 hours prior to your appointment to avoid a \$25 charge and to allow someone else to use that appointment time. A fee of \$25.00 is to be paid by the patient prior to scheduling the next appointment. This charge is not billable to insurance providers.

By signing, I acknowledge that I am aware of the policies set forth.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Signature of patient or authorized representative. If authorized representative, please state relationship to patient.

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

DATE: \_\_\_\_\_

**LEGAL ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL/PLAN DOCUMENTS:**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the previously listed company, and hereby assign and convey directly to Spine & Brain Neurosurgery Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor's expense.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Signature of patient or authorized representative. If authorized representative, please state relationship to patient.

I understand that I am entering into a contractual relationship with Spine & Brain Neurosurgery Center, Inc. for professional care. I understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Spine & Brain Neurosurgery Center, Inc., I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice.

Furthermore, should a meritorious medical malpractice claim or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use an ABMS board certified expert witness in the same or similar specialty. I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty societies for expert witnesses in the area of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, I (the physician), agree to the same stipulations.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Signature of patient or authorized representative. If authorized representative, please state relationship to patient.

PHYSICIAN SIGNATURE: \_\_\_\_\_

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**AUTHORIZATION TO RELEASE OR USE INFORMATION FOR  
TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS**

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by Spine & Brain Neurosurgery Center (from here forth referred to as "the Practice") in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised Notice upon request.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restrictions(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I agree that the Practice may also disclose the following types of information contained in my medical record (**please initial the appropriate categories listed below**):

- HIV/AIDS Information
- Substance Abuse Information
- If Patient is under the age of eighteen (18), Pregnancy Information
- Mental Health Information
- Sexually Transmitted Disease Information

I agree and consent to the Practice releasing information to me in the following alternative manners (**please initial the appropriate categories listed below**):

- Via email to the Patient's designated e-mail address which is: (I am responsible for notifying the practice of any changes to my e-mail address.) \_\_\_\_\_
- Via regular mail with any envelopes being marked personal/confidential and addressed to me.
- Via telephone, if I contact the Practice and provide the appropriate information (including name, social security number and unique personal identifier).
- Via fax to my designated fax number which is \_\_\_\_\_

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent. The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

**I have read and understand the information in this consent. I acknowledge and agree to the terms of this consent by signing below. I acknowledge that I may obtain a copy of this document upon request.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Signature of patient or authorized representative. If authorized representative, please state relationship to patient.

\_\_\_\_\_  
PLEASE PRINT NAME