



NEUROLOGICAL SURGERY, P.C.

PATIENT INFORMATION

Name _____ Birth Date _____ Age _____
Address _____ City _____ State _____ Zip _____
Phone: () _____ Cell: () _____ Work: () _____ Ext: _____
Sex M F Soc. Sec. #: ____/____/____ Single Married Widowed Separated Divorced

Occupation _____ Employer _____
Employer's Address _____

Referred By _____ Phone: () _____
Address _____

Primary Care Physician (PCP) _____ Phone: () _____
PCP Address _____

Emergency Contact/Relationship _____ Phone: () _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder's Name _____ ID# _____

Policy Holder's Birth Date _____ Policy Holder's SS# _____

Secondary Insurance _____ Relationship _____

Policy Holder's Name _____ ID# _____

Birth Date _____ SS#: ____/____/____ Group # _____

WORKER'S COMPENSATION or NO FAULT: *please circle one*

Insurance Company _____ DATE OF ACCIDENT _____

Address _____

Policy Number _____ Carrier Case # _____

Case Manager _____ Phone: () _____ Ext: _____

ASSIGNMENT AND RELEASE

I, the undersigned, authorize the release of any medical information necessary to process this claim.

I, the undersigned, authorize payment of medical benefits to Neurological Surgery, P.C. for professional services. I understand that I am responsible for any amount not covered by insurance.

Patient's Signature _____ Date _____

I acknowledge that I have received a copy of Neurological Surgery P.C.'s "Notice of Privacy Practices" ("Notice") as required by the Health Insurance Portability and Accountability Act of 1996. I understand that the Notice is intended to provide me with general information about Neurological Surgery, P.C.'s privacy practices with respect to Individually Identifiable Health Information, and that it is not a contract. I further understand that all of the policies and information contained in the Notice are subject to change by Neurological Surgery, P.C. with or without notice, in accordance with applicable law.

Patient's Signature _____ Date _____

MEDICAL HISTORY

PLEASE COMPLETE FORMS CAREFULLY

MAKE SURE TO ANSWER ALL QUESTIONS. SIGN AND DATE EACH PLACE INDICATED. THANK YOU.

NAME:

DATE:

I. What is the main complaint for which you are coming to this office?

II. What is the history of your present illness? (If you require additional space, please use back of page.)

- a. When did the problem start? _____
- b. Where is the problem located? _____
- c. Has it become worse? _____ better? _____ same? _____
- d. If you have pain, does the pain travel? _____ where to? _____
- e. Is the problem constant? _____ intermittent (on and off) ? _____
- f. If the problem is on and off, is it ____ daily? ____ weekly? ____ monthly? ____ other?
- g. What, if anything, makes it better?

- h. What, if anything makes it worse?

- i. What treatments have you had for this problem?

- j. Are there any other problems associated with your main problem?
 headache vision speech numbness
 dizziness hearing pain weakness

III. FAMILY HISTORY

A. Check the condition, and which family member has the condition (i.e. mother, father, brother, sister, son, daughter, etc.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Allergy _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Jaundice _____ |
| <input type="checkbox"/> Psychosis _____ | <input type="checkbox"/> Ulcer _____ | <input type="checkbox"/> Coronary Disease _____ |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Rheumatic Heart Disease _____ | <input type="checkbox"/> Hypertension _____ |
| <input type="checkbox"/> Gall Bladder Stones _____ | <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Bleeding Tendency _____ |
| <input type="checkbox"/> Thyroid _____ | <input type="checkbox"/> Nervous Breakdown _____ | <input type="checkbox"/> Kidney Stones _____ |
| <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Leukemia or Lymphoma _____ | |

- B. Mother Living Died at age _____ cause _____
- C. Father Living Died at age _____ cause _____

MEDICAL HISTORY

PLEASE COMPLETE FORMS CAREFULLY

MAKE SURE TO ANSWER ALL QUESTIONS. SIGN AND DATE EACH PLACE INDICATED. THANK YOU.

NAME: _____

DATE: _____

IV. HABITS

	AMOUNT	HOW LONG	WHEN CHANGED
♦ Alcohol	_____	_____	_____
♦ Tobacco	_____	_____	_____

- Height: _____
- Sleep _____ hours
- Weight: _____ lbs
- Eating Habits: Good Poor
- Gain _____
- Loss _____

V. CURRENT MEDICATIONS (attach a list or write below with does and times per day)

MEDICATION	DOSE	TIMES PER DAY	MEDICATION	DOSE	TIMES PER DAY

VI. SOCIAL HISTORY

- Marital Status: Single Married Divorced Widowed how long? _____
- Present Occupation: _____ How long? _____
- Prior Work: _____
- Exposure to Occupational Disease: Yes No When _____
- Travel _____

VII. PREVIOUS HEALTH AND ILLNESS

- A. General Health
1. Recent examinations and hospitalizations: _____
 2. Past medical illnesses: _____
 3. Past Surgeries: _____
 4. Radiation Therapy: _____
 5. Last Tetanus Booster: _____
 6. Transfusions: date: _____ amount: _____ reactions: _____
 7. Have you ever had a Tumor or Cancer? Where and when?: _____

MEDICAL HISTORY

PLEASE COMPLETE FORMS CAREFULLY

MAKE SURE TO ANSWER ALL QUESTIONS. SIGN AND DATE EACH PLACE INDICATED. THANK YOU.

NAME:

DATE:

VII. PREVIOUS HEALTH AND ILLNESS (continued)

B. Review of Systems (check and explain in # 11)

1. **ALLERGIES:** Asthma Food Hayfever Urticaria Inhalants
 Penicillin Drugs NONE

2. **HEAD:** Headache Visual Disturbance Dental Disease Sinusitis
 Earache Bleeding Gums Head Injury Tinnitus
 Upper Respiratory Infection Hearing Disturbance Nose Bleed NONE

3. **RESPIRATORY TRACT:** Pleurisy Sputum Hoarse Wheezing
 Hiccups Pneumonia Bronchitis TB
 Chronic Cough Spitting up Blood Other _____
 NONE Last Chest X-Ray _____

4. **CARDIAC:** Angina Hypertension (high blood pressure) Arrhythmia
 Cyanosis Heart Murmur Palpitations Edema
 Dyspnea (difficulty breathing) Enlarged Heart
 Nocturnal Dyspnea (difficulty breathing at night) NONE
 Last EKG _____
 Special Diagnostic Tests _____ Results _____

5. **GI (Gastro-intestinal):** Dysphagia (difficulty swallowing) Anorexia
 Bowel Habit Change Nausea Cramps
 Eructation (belching) Constipation Jaundice
 Hemorrhoids Heartburn Diarrhea
 Abdominal Pain Indigestion Hernia
 Hematemesis (vomiting blood) Black or Bloody Stool
 NONE Other: _____

6. **GU (Genito-urinary):**
 - a. Male/female Dysuria (difficulty urinating) Hematuria (blood in urine)
 Facial Edema (swelling) VD (venereal disease)
 Nocturnia (urinating at night) Urinary retention
 Frequency Back Pain Stones
 NONE Other: _____

 - b. Female Menarche Menses Regular LMP
 Abnormal Bleeding Last Pap Smear _____
 Post-menopausal bleeding Number of pregnancies _____
 Abortions _____ Number of children _____
 Other: _____

