

We want to advise you that sending health information to an unsecure email can place the information at risk of being read or accessed by someone else. If you do not want to return this form by email, then please fax completed forms to our secure fax number 214-823-3797 before your scheduled appointment date.

PATIENT INFORMATION

Name: Date of Birth:

Address:

City: State: Zip:

Mailing Address (If different than physical address)

Sex: Male Female Transgender

Marital Status: Single Divorced Married Partnered Widowed Legally Separated Other

Race: American Indian Asian Native Hawaiian Black or African American White Hispanic Other Race

Language: English Spanish Other

Employer: Occupation:

Home Phone: Preferred number Cell Phone: Preferred number

Work Phone: May we leave personal/medical personal/medical information on your voicemail Yes No

Email Address:

INSURANCE COVERAGE

Self Pay

Primary Insurance

Secondary Insurance:

No Secondary Coverage

Carrier: <input type="text"/>	Carrier: <input type="text"/>
ID #: <input type="text"/>	ID #: <input type="text"/>
Group #: <input type="text"/>	Group #: <input type="text"/>
Primary Card Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent <input type="checkbox"/> Other	Secondary Card Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent <input type="checkbox"/> Other
Name of Insured: <input type="text"/>	Name of Insured: <input type="text"/>
Insured's Date of Birth: <input type="text"/>	Insured's Date of Birth: <input type="text"/>

Does this visit pertain to a worker's compensation injury, personal injury, or motor vehicle accident? Yes No

Date of Injury: Claim Number:

Adjuster: Phone Number:

Name:

DOB:

EMERGENCY CONTACTS

Primary Emergency Contact

I authorize I do **NOT** authorize
the discloser of my protected health information (PHI) to
the person listed as my Primary Emergency Contact.

Name:

Phone Number:

Relationship: Spouse Partner Sibling Parent

Child Friend Other:

Secondary Emergency Contact

I authorize I do **NOT** authorize
the discloser of my protected health information (PHI) to
the person listed as my Primary Emergency Contact.

Name:

Phone Number:

Relationship: Spouse Partner Sibling Parent

Child Friend Other:

CIRCLE OF CARE

Referring Provider:

Phone Number:

Primary Care Provider:

Phone Number:

Cardiologist:

Phone Number:

Oncologist:

Phone Number:

Pain Management:

Phone Number:

HOW DID YOU HEAR ABOUT US?

Physician/ Provider Referral Family or Friend Website or Search Engine Other

PHARMACY

Name: Phone: Fax:

Address: City: Zip:

MEDICATION ALLERGIES

No Known Drug Allergies

Are you allergic to any of the following?

Latex Adhesives Contrast

Name:

DOB:

FAMILY HISTORY

Family History

Please place an **X** in the box if one of your immediate family members have been diagnosed with any of the following medical conditions.

- Anemia
- Depression
- Hepatitis
- Lupus
- Anxiety Disorder(s)
- Diabetes Type I
- High Blood Pressure
- Osteoarthritis
- Asthma
- Diabetes Type II
- HIV
- Rheumatoid
- Cancer: Type:
- DVT (Blood Clots)
- Kidney Disease
- Sleep Apnea
- Coagulation Defects
- Epilepsy/Seizures
- Low Blood Pressure
- Stomach Ulcers
- Colitis
- Heart Disease
- Lung Disease
- Stroke

SOCIAL HISTORY

Height:

Weight:

Right-Handed

Left-Handed

Advanced Directive

Do you have a living will? Yes No

Do you have a DNR (Do Not Resuscitate)? Yes No

If **YES**, please provide our office with a copy for your chart Yes No

Blood Products/ Transfusions

Do you have any objections to receiving blood or blood products? Yes No

Vaccination Information

Have you had a flu shot? Yes No

If **YES**, when was your last shot?

If over 65, have you had a pneumonia vaccine?

If **YES**, when was your last shot?

If **YES**, do you take aspirin? Yes No

Coronary Artery Disease & Prior Myocardial Infraction or Left Ventricular Dysfunction

Do you have coronary artery disease? Yes No

If YES, do you have a pacemaker? Yes No

If YES, do you take a Beta Blocker? Yes No

Fall: Risk Assessment

If over 65, have you had any falls in the past year? Yes No - If **YES**, please check one of the following about your fall:

One fall with injury in the past year

One fall without injury in the past year

Two or more falls with injury in the past year

Two or more falls without injury in the past year

Smoking/ Tobacco History

Have you ever smoked? No Yes If **YES**, how often and how much?

Are you currently a smoker? No Yes If **YES**, how often and how much?

What type of tobacco do you smoke? N/A Cigarettes Pipe Snuff

if you quit smoking, when?

Name:

DOB:

Alcohol Use

Have you had an alcoholic drink in the past year? Yes No

Do you currently drink alcohol? Yes No

If YES, what type of alcohol consumed in the past year

- Beer
- Wine
- Liquor

If YES, how often did you have an alcoholic drink in the last year?

- Monthly or less
- 2 to 3 times a week
- 2 to 4 times a month
- 4 or more times a week

If YES, how many drinks did you have on a typical day when you drank in the past year?

- N/A
- 1 to 2 drinks
- 3 to 4 drinks
- 5 to 6 drinks
- 7 to 9 drinks
- 10 or more

If YES, how often did you have 6 or more drinks on one occasion in the past year?

- N/A
- Less than a month
- Monthly
- Weekly
- Daily or Almost Daily

Drug Usage

Do you now or have you ever used recreational drugs? Yes No

If yes, please explain:

PRIOR SURGERIES/ PRIOR HOSPITALIZATIONS

<i>Prior Surgeries / Please list Month & Year performed</i>	<i>Prior Hospitalizations (Location & Why)</i>

PHYSICIAN ONLY SECTION

I have reviewed the listed ROS/PFSH/Screening with the patient and noted the positive/negative findings for the visit.

M.D. Signature: _____

Date of Service: _____

Name:

DOB:

REASON FOR VISIT

- New Patient
- Second Opinion
- Established Patient with New Symptoms

Symptoms:

CONSERVATIVE THERAPY

Your insurance may require conservative therapy before approving surgery. The following information will help with the approval of any diagnostic test to be ordered or surgery if needed

Have you had to use a: Cane Wheelchair Walker

Have you tried: Heat Ice Home Exercises Massage

Diagnostic Imaging: (Within a year from Appointment Date)

No Current Imaging

X-Ray(s) Cervical Thoracic Lumbar Wrist Other Facility/Location:

CT Cervical Thoracic Lumbar Brain Wrist Other Facility/Location:

MRI(s) Cervical Thoracic Lumbar Brain Wrist Other Facility Location:

Yes No **Medication Only** Type: NSAID(s) Steroid(s) Muscle Relaxer(s) Anti-Inflammatory(s) Other:

Yes No **Physical Therapy** Location:

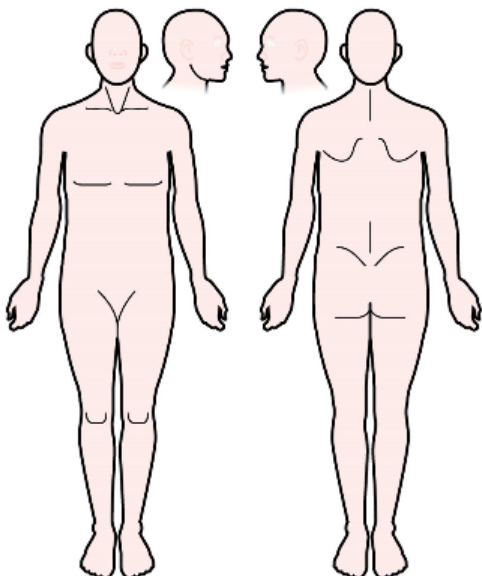
Yes No **Chiropractic Care** Physician Name:

Yes No **Pain Management** Physician Name:

Yes No **Epidural Steroid Injections** Cervical Thoracic Lumbar **Facet Injections:** Yes No

Other Procedure(s) or Treatment(s):

Have you missed work for this condition? Yes No



PAIN DIAGRAM

Mark these drawings according to where you hurt. Please include all affected areas.

How long have you experienced this pain?

Please indicate your pain level now:

- No pain 1 2 3 4 5 6 7 8 9 10

If there are multiple locations of pain, please rate each pain on the body diagram.

Please give us a written description if you cannot mark the diagram:

Name:

DOB:

TEXAS NEUROSURGERY

ACKNOWLEDGEMENT FORM

By signing my name below, I:

- Consent to receive the following documents electronically which are available through our website unless I request a non-electronic paper copy of the documents disclosed herein.
 - Texas Neurosurgery's Notice of Privacy Practice
 - Texas Neurosurgery's Financial Policy
 - Texas Neurosurgery's Disclosure of Physician Ownership
 - Texas Neurosurgery's Medication Policy/Agreement
 - Texas Neurosurgery's Physician Assistant Information Guide
- Authorize:
 - The release of any medical and/or other information necessary to process my claim(s)
 - Payment of medical benefits to my treating physician or supplier for services rendered by Texas Neurosurgery.
- **I have read and understand/agree to abide by all the above policies of Texas Neurosurgery.**

Patient/ Guardian Signature

Date