TEXAS NEUROSURGERY, L.L.P

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

Carrier:

ID #:

Group #:

Primary Card Holder: ☐Self ☐Spouse/Partner ☐Parent ☐ Other

Name of Insured:

Insured's Date of Birth:

Secondary Insurance: ☐*No Secondary Coverage*

Carrier:

ID #:

Group #:

Secondary Card Holder: ☐Self ☐Spouse/Partner ☐Parent ☐Other

Name of Insured:

Insured's Date of Birth:

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: _____

CURRENT MEDICATIONS *(Please include Supplement(s), Over the Counter and Prescribed Medication(s))*

Prescription Name	Dose	Frequency	Reason Prescribed

REVIEW OF SYSTEMS

Do you currently have any of the following symptoms? (Within the last 6 months) ☐ No Issues

☐ Anxiety	☐ Dizziness/Vertigo	☐ Irregular Heartbeat	☐ Seizures	☐ Urinary: Frequent
☐ Back Pain	☐ Easy Bleeding	☐ Joint Pain	☐ Shortness of Breath	☐ Urinary: Painful
☐ Burning w/ Urination	☐ Easy Bruising	☐ Morning Joint Stiffness	☐ Sinus Drainage	☐ Visual Changes
☐ Chest Pain	☐ Fatigue	☐ Nausea	☐ Sore Throat	☐ Vomiting
☐ Cough	☐ Fever/ Chills	☐ Neck Pain	☐ Swelling	☐ Weight Gain
☐ Depression	☐ Headaches	☐ Palpitations	☐ Toothache	☐ Wheezing
☐ Diarrhea	☐ Hearing Loss	☐ Rash	☐ Ulcers/ Lesions	

PERSONAL HISTORY

Personal History

Please place an X in the box if you 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

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 4 times a month

☐ 2 to 3 times a week ☐ 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 ☐ 3 to 4 drinks ☐ 7 to 9 drinks

☐ 1 to 2 drinks ☐ 5 to 6 drinks ☐ 10 or more

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

☐ N/A ☐ Monthly ☐ Daily or Almost Daily

☐ Less than a month ☐ Weekly

Drug Usage

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

If yes, please explain: _____

PRIOR SURGERIES/ PRIOR HOSPITALIZATIONS

Prior Surgeries / Please list Month & Year performed	*Prior Hospitalizations (Location & Why)*

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: _____

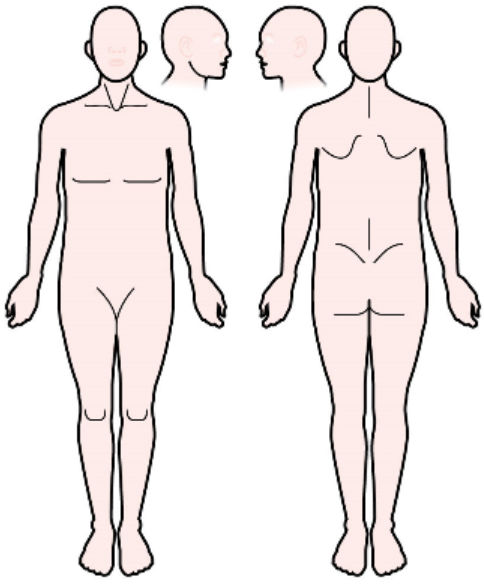
☐ Yes ☐ No **Chiropractic Care** Physician Name: _____

☐ 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**