Texas Neuro Spine Institute, P.A.
Patient Information Form

Patient Account Number	Doctor	Date

Patient Name _____
Last First Middle

Patient Address _____ Apt. _____

City _____ St. _____ Zip _____

Home Telephone Number _____ Mobile Number _____

Patient Date of Birth _____ Social Security Number _____

Please Circle One: Single / Married / Divorced / Widowed Sex: Male / Female

Patient Employer _____ Occupation _____

Phone Number _____ Employer Address _____

City _____ St. _____ Zip _____

Primary Insurance Information

Referring Doctor _____ Phone Number _____

Primary Care Doctor _____ Phone Number _____

Primary Insurance Name _____

Claims Mailing Address _____

City _____ St. _____ Zip _____

Member Identification Number _____ Group Number _____

Insurance Type: HMO, PPO, EPO, POS, other Is a referral required? Yes or No

Co-pay Amount _____

Subscriber Information

The subscriber is the policy holder.

Subscriber Name _____ Date of Birth _____

Social Security Number _____ Relation _____

Employer _____ Telephone Number _____

Secondary Insurance Information

Secondary Insurance Name _____

Claims Mailing Address _____

City _____ St. _____ Zip _____

Member Identification Number _____ Group Number _____

Subscriber Name _____ Date of Birth _____

Social Security Number _____ Relation _____

Employer _____ Telephone Number _____

Workers Compensation Information

Did your injury occur on the job? Yes or No
Are you claiming workers' compensation? If so, please answer the following questions:

Adjuster's Name _____ Phone _____

Name of Insurance Company _____

Claim Number _____ Date of Injury _____

Emergency Contact Information

In case of an emergency, if we are not able to contact you, we need the name of someone outside the home so we can get in contact with you.

Contact Person Name _____ Phone _____

Relation _____

Name _____ DOB _____ Acct # _____

Privacy Policy and Medical Records Release

My signature below indicates that I have reviewed a copy of the "Notice of Privacy Practices" for Texas Neuro Spine Institute, and that if I have any questions regarding this notice, that I can discuss it with the designated Privacy Officer.

Below is my list of people with whom I give permission to discuss my healthcare. This does not include doctors and Workers' Compensation. Records are routinely released to referring physicians and adjusters with Workers' Compensation.

1. _____

2. _____

3. _____

4. _____

5. _____

Patient Signature _____ Date _____

Do you have an advanced directive? Yes or No

I agree to the assignments and financial responsibilities shown below on this form.

Patient Signature _____ Date _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. I authorize the release of any information necessary to determine liability of payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges whether or not paid by said insurance.

Name _____ DOB _____ Acct # _____

Patient Evaluation

1. Age _____
2. Right Left Handed
3. Male Female Females: pregnant or nursing? _____
4. Your current / past occupation _____
5. Single Married Divorced Separated Widowed
6. Height _____ foot _____ inches
7. Weight _____ lbs
8. Who is going to be looking after you? _____
9. How many daughters do you have? _____ How old are they? _____
10. How many sons do you have? _____ How old are they? _____
11. Do you smoke? _____ How many packs a day? _____
    When did you quit smoking? _____

What is the main **problem** that you want us to help you with? (pain, numbness, weakness)

_____

Tell us more about this problem. How severe is it? Minor, moderate, severe
What is the exact location of the problem? (arms, legs, head, back)

_____

When did the problem start? (date)

_____

How did the problem start? (lifting, trauma)

_____

When during the day or night does the problem occur or worsen?

_____

What makes the problem worse? (standing, sitting, laying down, coughing)

_____

What makes the problem better? (Medication, leaning over a cart while shopping)

_____

List your other medical conditions (bleeding problems, heart attacks, infections, diabetes, hypertension, respiratory problems).

1. _____
2. _____
3. _____
4. _____

Name _____ DOB _____ Acct # _____

What surgeries, hospitalizations, trauma, have you had in the past? What year? Which hospital? Which surgeon?

1. _____
2. _____
3. _____
4. _____

Are you allergic to any medications, foods, x-ray or iodine contrast, adhesive tape, latex, rubber or anything else?

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____

List all medications (prescription, over the counter, herbal, etc.) that you take. Please include the medication name, how many milligrams, how many times a day, and for what purpose you take it.

Medication	Dose	Frequency	Reason

Are there any of the following in your immediate family?
Heart disease_____ Cancer_____ Diabetes_____ Blood disorders _____
Neurological disorders (strokes)_____ Tuberculosis _____ Other _____

Do you drink alcohol?_____ Occasionally_____ daily_____ every week _____
Have you ever used the drugs listed? Marijuana, cocaine, heroin, other_____

Is this a workers' compensation case? _____
Is there a lawsuit planned, relating to your problem injury?_____
If yes, against whom?_____ Attorney _____

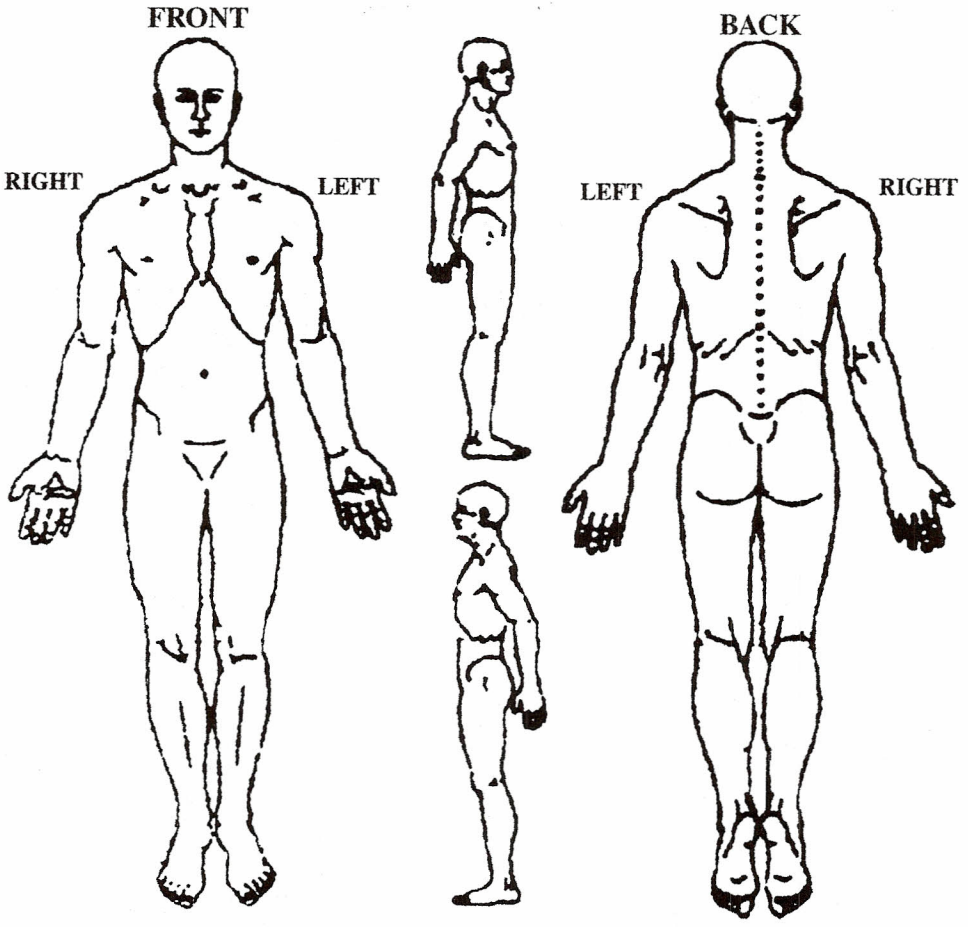
My signature signifies that I have read, answered, and understand the above information.

Patient/Guardian Signature _____ Date _____

Name _____ DOB _____ Acct # _____

Patient Evaluation and Management Services - History

Please outline the areas on your body where you feel the described sensations. Please indicate which feeling affects the outlined area: Numbness, Pins/Needles, Burning, Stabbing, Dull, and Aching.



_____ _____

Patient Signature Date

Name _____ DOB _____ Acct # _____

Patient Evaluation and Management Services - History

Review of Systems: Please check the box (es) if you currently have any of these symptoms. Patient Signature Date

Yes	Comment - for medical staff only	Yes	Comment - for medical staff only
● General ☐ Fever ☐ Night sweat ☐ Weight Loss ● Eyes ☐ Poor vision ☐ Blurry vision ☐ Double vision ● Ears, Nose, Mouth and Throat ☐ Loss of hearing ☐ Ringing in ears ☐ Decreased ability to smell ☐ Difficulty swallowing ☐ Hoarseness ☐ Slurred speech ● Cardiovascular ☐ Shortness of Breath ☐ Chest pain ☐ Irregular heart beat ☐ Palpitations ● Respiratory ☐ Chronic cough ☐ Coughing blood ☐ Emphysema ☐ Bronchitis ☐ Asthma ● Gastro-intestinal ☐ Weight loss ☐ Blood in stool ☐ Dark colored stool ☐ Abdominal pain ☐ Hernia ☐ Difficulty swallowing ☐ Nausea ☐ Vomiting ☐ Abdominal swelling ☐ Diarrhea ☐ Constipation ☐ Abdominal mass ● Genito-Urinary ☐ Burning on urination ☐ Dark or discoloring urine ☐ Difficulty starting or ending stream ☐ Poor control of bladder ☐ Excessive thirst ☐ Sexual dysfunction ☐ Inability to obtain / maintain erection		● Musculoskeletal ☐ Swelling of limbs ☐ Masses in limbs ☐ Loss of control of arms or legs ☐ Loss of muscle bulk ☐ Aching joints ☐ Neck pain ☐ Neck spasm ☐ Cramps ☐ Weakness ● Skin and breast ☐ Dry skin ☐ Discharge from nipples ● Brain, Spinal Cord, Nerves ☐ Dizziness ☐ Seizure ☐ Abnormal arm or leg sensations ☐ Arm or leg weakness ☐ Poor coordination ☐ Numbness ☐ Tingling ☐ Loss of sensation ● Psychiatric / Emotional ☐ Disorientation ☐ Depression ☐ Hallucination ☐ Anxiety ● Endocrine ☐ Discharge from nipples ☐ Poor appetite ☐ Cold intolerance ☐ Dry skin ☐ Excessive thirst ☐ Loss of body hair ☐ Weight gain ☐ Weight loss ☐ Easy Fatigue ● Hematology / Lymphatic ☐ Bleeding, clotting, disorder ● Allergic / Immunologic ☐ Allergic to inhaled pollen, etc. ☐ Decreased immune system / response ☐ AIDS	

Name _____ DOB _____ Acct # _____