Patient Information Form

Patient Information

First Name: ____________________ Last Name: _______________________ Date: _______

DOB: ____________ Age: _____ SSN: _______________ Gender: ☐ Male ☐ Female ☐ Other

Home Address: ____

City: ______________________ State: _________ ZIP: ________

Primary Phone: (_____) _____________ Email: _______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Occupation/Employer: _______________________________ Employed? ☐ Yes ☐ No

Emergency Contact Name: _______________________________

Relationship:____________ Phone: (_____) _____________

Pharmacy Information

Pharmacy Name: ______________________ Phone: (_____) _____________

Address: ____

Referring & Primary Care Providers

Referring Physician: _______________________________ Phone: (_____) _____________

Primary Care Physician: _______________________________ Phone: (_____) ___________

Texas Neuro Spine Institute

Patient Information Form

Insurance & Financial Information

Primary Insurance: ________________________ Policy/ID #: __________________________
Group #: ________________

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

Subscriber Information

Policy Holder Name: ___________________________ DOB: ___________

Relationship to Patient: _______________ SSN: ___________________

Secondary Insurance (if applicable): ____________________ Policy/ID #: _________________

Workers Compensation Information

Is this visit related to: ☐ Workers' Compensation ☐ Motor Vehicle Accident ☐ Personal Injury/Litigation ☐ None

If yes, please fill out the following:

Date of injury/accident: _________

Name of Insurance Company: _______________ Claim #: ________________

Attorney Name/Phone: ________________________________

Adjuster’s Name/Phone: ________________________________

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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 a list of people with whom I give permission to discuss my healthcare. This does not include doctors and Worker’s compensation. Records are routinely released to referring physicians and adjusters with Worker’s Compensation.

1. ____

2. ____

Signature: _______________________________ Date: __________

Financial Responsibility Policy

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, nad 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 the office visit 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 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 valid as an original. I understand that I am responsible for all changes whether or not paid by insurance.

Signature: _______________________________ Date: __________

Patient Information Form

Chief Complaint & Symptom History

Main reason for visit / chief complaint:

When did your symptoms first begin? Month/Year: _______________

How did symptoms start? ☐ Sudden (e.g., injury/fall/trauma) ☐ Gradual ☐ Other:___________

Describe symptoms (check all that apply): ☐ Pain ☐ Numbness/Tingling ("pins & needles")

☐ Weakness ☐ Shooting/"Lightning" pain ☐ Burning ☐ Aching ☐ Spasms/Cramping ☐ Balance ☐ Dizziness/Vertigo ☐ Headaches ☐ Seizures ☐ Memory/Cognitive changes ☐ Vision changes ☐ Bowel/Bladder issues

Pain/Discomfort Location & Radiation: (Use body diagram if available)

- Neck pain? Yes/No → Radiates to: ☐ Shoulders ☐ Arms ☐ Hands
- Back pain? Yes/No → Radiates to: ☐ Hips ☐ Legs ☐ Feet
- Other areas: ________________________________

Pain severity without medications (0–10 scale, 0 = none, 10 = worst imaginable):

- ___________________

What makes symptoms **worse**? (e.g., sitting, standing, walking, bending, coughing/sneezing, lying down):

What makes symptoms **better**? (e.g., rest, ice/heat, position change, medication):

Impact on daily life: Interferes with sleep? ☐ Yes ☐ No Unable to work? ☐ Yes ☐ No Unable to perform hobbies/chores? ☐ Yes ☐ No

Patient Information Form

Medical, Surgical & Family History

Past Medical History (Check Y/N and explain if Yes):

☐ High Blood Pressure ☐ Diabetes ☐ Stroke/TIA ☐ Heart Disease/Heart Attack

☐ Cancer (type: ___________________________)

☐ Seizures/Epilepsy ☐ Multiple Sclerosis ☐ Parkinson's ☐ Thyroid Disorder ☐ Bleeding/Clotting Disorder ☐ Asthma/COPD ☐ Kidney Disease ☐ Liver Disease ☐ Depression/Anxiety

☐ Osteoporosis Other relevant conditions:_________________________________

Past Surgical History (List all, especially spine/brain/neck):

Surgery Type	Date	Surgeon	Complications?

Allergies: List medications, contrast dye/adhesive tape, latex, rubber, or anything else. Include reaction severity. If none, please write no known drug allergies (NKDA).

Allergy	Reaction

Patient Information Form

Medications (List all current prescriptions, OTC, supplements, herbals):

(Attach list if needed: "See attached")

Medication	Dose	Frequency	Reason

Social History

Tobacco: ☐ Current (packs/day: _____) ☐ Former (quit year: __________) ☐ Never

Alcohol: ☐ None ☐ Occasional ☐ Regular (drinks/week: _____)

Recreational drugs/substance use: ☐ Yes ☐ No If yes, which: ________________

Family History (Relevant neurological/medical conditions in blood relatives):

Parents/Siblings/Children: ____

Patient Information Form

Diagnostic Tests & Prior Treatments

Recent imaging/tests for this issue (bring CDs/films + reports):

☐ MRI Location: ______________________ Body part: _____ Reports? ☐ Yes

☐ CT/CT Myelogram Location: _____

☐ X-ray Location: _____

☐ EMG/Nerve Conduction Study Date: _____

Prior treatments tried:

Physical Therapy? ☐ Yes (dates/sessions: _____) ☐ No

Chiropractic? ☐ Yes ☐ No

Injections (e.g., epidural/steroid)? ☐ Yes (how many/last date: _____) ☐ No

Pain medications/narcotics? ☐ Yes ☐ No

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Medication Prescription Refill Policy

As a reminder to our patients, this is a surgical practice. It is not our practice to provide pain management medications to patients who have not undergone a surgical procedure by this office. **Pain medications will only be prescribed in the immediate post operative period (3 months).** Use of pain medications beyond the immediate post operative period will be managed by a pain management physician.

Refill requests for medications prescribed by our office will be accepted only during regular business hours which are Monday - Friday from 9PM to 5PM. Please allow 1 business day for refills to be processed.

Signature: ________________________________ Date: ________

Policy Regarding Medical Leave and Disability Forms

To ensure the highest quality of surgical care and provide accurate medical documentation based on our direct treatment, our practice has established the following policy regarding the completion of medical leave and disability-related paperwork:

- We will complete **Family and Medical Leave Act (FMLA) forms**, short-term disability forms, long-term disability forms, state paid family/medical leave forms, workers' compensation forms, and similar medical certification documents **only for patients who have undergone surgery or are under active post-surgical care in our office**.
- A non-refundable **completion fee of $25** will be charged in advance for completion. We cannot bill this fee to insurance.
- This policy allows us to provide precise and reliable information based on our firsthand knowledge of your surgical procedure, recovery progress, and any related work restrictions. We will make every effort to complete and return/fax forms within **10 business days.**
- We are unable to complete these forms for non-surgical conditions, pre-existing medical issues unrelated to your surgery in our practice, or for patients who are not established surgical patients under our care.

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Signature: ________________________________ Date: ___________