PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: _____ Marital Status: _____ E-Mail Address: _____

INSURANCE INFORMATION

Primary Insurance

Subscriber's Name: _____ SSN: _____ DOB: _____

ID#: _____ Group#: _____ Co-Pay Amount: _____

Secondary Insurance

Subscriber's Name: _____ SSN: _____ DOB: _____

ID#: _____ Group#: _____ Co-Pay Amount: _____

WORKER'S COMPENSATION INFORMATION

Worker's Comp Carrier: _____ Claim#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Contact Name: _____

Copies to: _____

Responsible Party:

Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____ Relationship to Patient: _____

Your signature confirms that all of the above information is correct and authorizes *ARCH Neurosurgery* to correspond with the physicians listed above. I authorize the release of information to m insurance company, including Medicare, I also authorize insurance benefits to be paid directly to ARCH Neurosurgery. I understand I am responsible for all deductibles, co-insurance, and non-covered services that may be required. In addition, I agree to pay for any additional charges related to the cost of collection in the event I fail to pay my bill. If signed by a guardian or parent, this is also an authorization for medical treatment of a minor. A photocopy of this document is to be considered as valid as the original.

Patient Signature: _____ Date: _____

DATE_____

Name_____ Date of Birth_____ Referring MD_____

Primary Healthcare Provider_____

Male____ Female ____ Height_____ Right or Left Handed _____

Weight_____

Chief Complaint: Please describe injury/complaint & how long condition has been present

_____

What makes your symptoms better (ie. rest, medication)_____

What makes your symptoms worse? (ie. walking, bending) _____

Which symptom has caused you the most concern?_____

Date of onset/injury_____ Were you in an auto accident?_____

Work related injury? YES NO Caseworker_____

Have any x-rays or tests been performed? YES NO

Name of test _____

Date_____ Location_____

Have you had any prior treatment for this problem? Describe._____

Past Medical History

- ☐ Heart attack
- ☐ Angina
- ☐ Congestive heart failure
- ☐ Mitral valve prolapse
- ☐ High blood pressure
- ☐ High cholesterol/Triglycerides
- ☐ Heart disease
- ☐ Arrhythmia
- ☐ Anemia
- ☐ Stroke
- ☐ Bleeding disorder
- ☐ Blood clots (DVT)
- ☐ Peripheral vascular disease
- ☐ Peripheral neuropathy
- ☐ Cancer
- ☐ Fractures
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Psychiatric history
- ☐ Anxiety
- ☐ Depression
- ☐ Schizophrenia
- ☐ Headaches
- ☐ Lung disease
- ☐ Emphysema (COPD)
- ☐ Pneumonia
- ☐ Chronic Bronchitis
- ☐ Blood clot in lung
- ☐ Tuberculosis
- ☐ Hiatal Hernia
- ☐ Reflux
- ☐ Stomach or intestinal ulcers
- ☐ Peptic ulcer disease
- ☐ Crohn's disease
- ☐ Problems with anesthesia
- ☐ Fibromyalgia
- ☐ Ulcerative colitis
- ☐ Irritable bowels
- ☐ Diverticulitis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Hepatitis
- ☐ Liver Problems
- ☐ Diabetes-Insulin? Yes No
- ☐ Thyroid disease
- ☐ Kidney Stones/Disease
- ☐ Urologic problems
- ☐ Stress incontinence
- ☐ Enlarged prostate
- ☐ Frequent urinary infections(UTI)
- ☐ HIV+
- ☐ Intestinal bleeding

Prior Surgeries or Hospitalizations_____

_____

Current Medicines & Dosage _____

_____

Allergies

Known drug allergies?	YES	NO	Name allergic med/substance:
Known food allergies?	YES	NO	_____
Known latex allergy?	YES	NO	
Known metal allergy?	YES	NO	

FAMILY HISTORY (Please circle any conditions present in your biological mother, father or siblings)

Heart Disease	Cancer	High Blood Pressure	Stroke
Lung Disease	Liver Disease	Kidney Disease	Diabetes
Osteoporosis	Arthritis	Rheumatoid Arthritis	Psychiatric Disease
Anesthesia Difficulties		Other Inherited Disease (Type)	

Bleeding disorders: _____ relationship

SOCIAL HISTORY

Occupation_____
Work demands: _____Sedentary _____Moderately active _____Heavy labor
Work status (check one) _____Working _____Retired _____Disabled _____Other_____
Education level: _____Grade School _____High School _____Technical _____Associate
_____Bachelors _____Masters _____Doctorate
Marital status: _____Single _____Married _____Separated _____Divorced _____Widowed
Tobacco use: Yes No Packs per day for _____years (if stopped when? _____)
Alcohol use? Yes No Amount
Have you used illegal drugs? Yes_____ No_____ Have you injected illegal drugs? Yes_____ No_____
Do you exercise regularly? Yes No Describe _____
What sports/activities do you participate in? _____

CURRENT MEDICAL STATUS/ROS (Please check all that apply)

☐ good general health	☐ wheezing	☐ dry skin/itching
☐ recent weight change	☐ spitting up blood	☐ chronic skin ulcers
☐ fever	☐ change in bowel habits	☐ varicose veins
☐ fatigue	☐ loss of appetite	☐ numbness/tingling
☐ eye disease/injury	☐ nausea/vomiting	☐ blackouts
☐ glasses/contacts	☐ diarrhea	☐ tremors
☐ blurred/double vision	☐ constipation	☐ paralysis
☐ hearing loss/ringing	☐ indigestion	☐ depression
☐ chronic sinus problem	☐ burning/painful urination	☐ memory loss or confusion
☐ nose bleeds	☐ frequent urination	☐ nervousness
☐ difficulty swallowing	☐ bloody urine	☐ insomnia
☐ shortness of breath	☐ joint pain	☐ slow to heal after cuts
☐ chest pain	☐ back pain	☐ bruising tendency
☐ palpitations	☐ difficulty walking	☐ transfusions
☐ faintness	☐ muscle weakness	☐ excessive thirst
☐ breathing problems	☐ leg cramps	☐ excessive sweating
☐ chronic/frequent coughs	☐ rashes	

The above information is correct.and accurate to the best of my knowledge. I understand the need to inform my provider of any changes in my medical condition.

Signature_____Date_____

(rev. 4/8/09)

Today's Date Patient Name:

Patient Medication List

Please list ALL medications (including prescription, over –the-counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

Medication	Dosage	Frequency	Route of Administration

CONSENT TO RELEASE INFORMATION

PATIENT'S NAME_____

Patients' date of birth_____

You may leave a message on my answering machine at my home. YES_____ NO_____

You may leave a message on my voice mail at my work. YES_____ NO_____

I understand that it is my responsibility to provide authorization to Arch Neurosurgery in order to release any medical information regarding my care. I hereby authorize Arch Neurosurgery to release medical information to the following:

_____ (Spouse)

_____ (Significant other)

_____ (Parent)

_____ (Sibling)

_____ (Friend)

_____ (Employer)

_____(Other)

By signing this release I am authorizing any employee of Arch Neurosurgery to either provide verbal or written information regarding my medical condition to the above named individual(s). This authorization may be canceled by me at any time written notification.

_____ _____

Patient's signature Date

Arch Neurosurgery, LLC

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Arch Neurosurgery, LLC, creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the Notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will provide me with a copy of any revised notice.

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions request.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I requested on the use and disclosure of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

(PATIENT'S NAME PRINTED) (DATE)

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) (DATE)