Dallas Neurosurgical & Spine

Patient Information

First Name: _____ Last Name: _____ Middle Initial: ___ Date: _____

DOB: _____ Age: _____ SSN: _____ Sex: ☐ Male ☐ Female

Primary Language:

☐ Arabic ☐ French ☐ Italian ☐ Portuguese ☐ Declined
☐ Chinese ☐ German ☐ Japanese ☐ Russian ☐ Other
☐ English ☐ Greek ☐ Korean ☐ Spanish ☐ N/A
☐ Filipino ☐ Hindi ☐ Polish ☐ Vietnamese

Race:

☐ American Indian/Alaska Native ☐ Black/African American ☐ Nat Hawaiian/Pacific Islander
☐ Asian ☐ Hispanic ☐ White ☐ Declined ☐ Other Race

Religion:

☐ Buddhist ☐ Hindu ☐ Jewish ☐ N/A
☐ Catholic ☐ Islam ☐ Protestant ☐ Other

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Do you consent to Dallas Neurosurgical & Spine requesting and using your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes?

☐ Yes ☐ No

Preferred Pharmacy: _____ Location: _____ Phone: _____

Doctor: ☐ Denning ☐ Desaloms ☐ Jackson ☐ Krumerman ☐ Satyan ☐ Taub ☐ Weiner

Home Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred Communication: _____

Occupation: _____

Employer: _____ Work Phone: _____ Years Employed: _____

Employer Address: _____

Spouse Name: _____ Spouse SSN: _____ DOB: _____

Name of Referring Physician: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Address: _____

How Did You First Hear About Us?

☐ Friend or Family ☐ Internet Search ☐ Mass Media (Magazine, Radio, etc.)

☐ Physician Referred ☐ Web Site ☐ Yellow Pages ☐ Other: _____

Emergency Contact

Name: _____ Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other

Home Phone: _____ Work Phone: _____

Name: _____ Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other

Home Phone: _____ Work Phone: _____

Health Insurance Information

Primary Insurance: _____

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

Phone: _____ ID/Policy #: _____ Group/Acct #: _____

Name of Policy Holder: _____ DOB: _____

Secondary Insurance: _____

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

Phone: _____ ID/Policy #: _____ Group/Acct #: _____

Name of Policy Holder: _____ DOB: _____

Did Your Injury Occur at Work? ☐ Yes ☐ No Date of Accident: _____

Motor Vehicle Accident? ☐ Yes ☐ No Date of Accident: _____

All professional services are charged to the patient and necessary insurance forms will be completed on their behalf to expedite carrier payments. The patient is responsible for all fees (co-pays, deductibles, etc.) and payment is due at the time office services are rendered. In the event surgery is performed, any fees due from the patient will be expected in a timely manner.

Insurance Authorization and Assignment (Please Read and Sign):

I hereby authorize Dallas Neurosurgical and Spine to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical and/or surgical benefits to which I am entitled for medical services rendered to myself or my dependents. I understand that I am responsible for all applicable fees. A photo copy of this assignment is to be considered as valid as an original. I authorize my records to be transmitted electronically and absolve Dallas Neurosurgical and Spine for any and all liability if they are received by another party in error.

Please Sign _____ Date _____

(Signature of Patient or Parent if Minor)

DALLAS NEUROSURGICAL AND SPINE ASSOCIATES, P.A.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At **Dallas Neurosurgical and Spine Associates, P.A.** (hereinafter referred to as the "the Practice"), privacy is one of the highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name, address and claims information. We use this information to provide service to you, to process your claims and bring you health information that might be of interest to you.

Keeping information accurate

Keeping your information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How-and why-information is shared

We limit who receives information and what type of information is shared.

- *Sharing information with the Practice.* We share information within our company to deliver you the health care services and related information and education programs specified to your plan.

- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly

to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide us-whether it's at our office, over the phone or through the Internet.

Dallas Neurosurgical and Spine Associates, P.A.
8230 Walnut Hill Lane, #220
Dallas, TX 75231
214-750-3646

July 2008

Print Form

DALLAS NEUROSURGICAL AND SPINE ASSOCIATES, P.A.

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, Dallas Neurosurgical and Spine Associates. P.A. creates and maintains health records and other information describing among other things, my health history, symptoms, examinations 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 mail a copy of any revised notice to the address I have provided. 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, permium rating, conducting or arranging for medical review, legal services, and auditing functions, etc) and that the organization is not required to agree to the restictions requested.

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 been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written, 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 request on the use and disclosure of my protected health information which have prevoiusly been agreed upon.

Patient Name (please print) _____ Current Date 7/3/18

Patient Signature
(or Guardian if a minor) _____ SSN _____

Witness Signature
(optional) _____ Date _____

DALLAS NEUROSURGICAL AND SPINE ASSOCIATES, P.A.

HIPAA COMPLIANCE

(HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)
EFFECTIVE: APRIL 14, 2003

RELEASE OF MEDICAL INFORMATION

Dallas Neurosurgical and Spine Associates, P.A. has a legal, ethical and moral obligation to protect your confidentiality. Any information about you will be held strictly confidential.

I, _____ hereby authorize Dallas Neurosurgical and Spine Associates, P.A. (which includes physicians, nurses, and staff) to release all medical records/ information including verbal conversations, medical records, radiology films, and written prescriptions for pick up).

SPOUSE _____

REFERRING PHYSICIANS ALL

PARENT/OTHER _____

PATIENT'S SIGNATURE _____

DATE _____

WITNESS (OPTIONAL) _____

Oct 2008

Physician Disclosure of Financial Interest

Thank you for the opportunity to provide your neurosurgical needs. We are committed to assuring your complete satisfaction.

The purpose of the disclosure notice is to inform you that we, the physicians at Dallas Neurosurgical & Spine, have financial interests in the following facilities in North Texas – Texas Institute for Surgery, Methodist Hospital for Surgery, and Crown Imaging.

Your physician may also have a financial interest in the professional component of intraoperative monitoring that is provided during selected surgical procedures, as well as in companies that provide implants for certain surgical procedures.

You have the right by law to choose the provider of your health care services as well as the option of utilizing an alternate medical facility, monitoring or implant company.

You will not be treated differently by your physician if you choose to obtain health care services at another facility, or to utilize another monitoring or implant company, if applicable. We welcome you as a patient and value our relationship with you.

If you have any questions concerning this notice, please feel free to ask your physician. By signing this Disclosure of Physicians Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has a financial interest in the listed facilities and other above stated services.

_____ _____

Signature of Patient

Signature of Parent or Guardian (if applicable)

_____ _____

Type or Print Name of Patient

Type or Print Name of Parent or Guardian (If applicable)

Dated: _____

Dallas Neurosurgical and Spine Associates, P.A
Patient Health History

Name: _____ DOB: _____ Date: _____

Reason for your visit (Chief complaint): _____

Past Medical History

Please check corresponding box if you have ever had any of the following medical conditions:

Heart Problems	
Congestive Heart Failure	☐
Deep Vein Thrombosis	☐
Heart Attack	☐
Heart Murmur	☐
High Blood Pressure	☐
High Cholesterol	☐
Irregular Heartbeat (Atrial Fibrillation)	☐
Other: _____	☐

Lung Problems	
Asthma	☐
Chronic Obstructive Pulmonary Disease	☐
Emphysema	☐
Pneumonia	☐
Pulmonary Embolism	☐
Other: _____	☐

Gastrointestinal Problems	
Cirrhosis	☐
Gastric ulcer	☐
Gastroesophageal Reflux Disease	☐
Hepatitis	☐
Rectal bleeding	☐
Other: _____	☐

Endocrine Problems	
Diabetes, Type I (Juvenile Onset)	☐
Diabetes, Type II (Adult Onset)	☐
Thyroid disorder – Type: _____	☐
Other: _____	☐

Musculoskeletal	
Fibromyalgia	☐
Osteoarthritis	☐
Osteoporosis	☐
Rheumatoid Arthritis	☐
Other: _____	☐

Neurological	
Alzheimer's Disease	☐
Cerebral Aneurysm	☐
Closed Head Injury	☐
Essential Tremor	☐
Hydrocephalus	☐
Migraines	☐
Multiple Sclerosis	☐
Parkinson's Disease	☐
Peripheral Neuropathy	☐
Seizure Disorder	☐
Stroke	☐
TIA	☐
Other: _____	☐

Urinary Problems	
Kidney Infection (pyelonephritis)	☐
Kidney Stones	☐
Prostate enlargement	☐
Urinary Tract Infection	☐
Other: _____	☐

Blood Disorders	
Anemia	☐
Bleeding Disorder	☐
Blood transfusion	☐
HIV +	☐
Other: _____	☐

Cancer	
Type: _____	☐
Type: _____	☐

Anesthesia	
Have you ever had a reaction to anesthesia?	☐
Please Describe: _____	☐

Other: _____	

Name: _____

Past Surgical History

Please list all previous surgeries:

	Date	Procedure	Surgeon
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Preferred Pharmacy

Please provide contact information for your preferred pharmacy:

Pharmacy Name	Address	City	State	Zip	Phone

Medications

Medication (please include prescription, over the counter and herbal)	Dose (mg)	Times Taken Per Day

Drug Allergies and Reactions

Drug	Allergic Reaction

Name: _____

Family Medical History

Please list any medical conditions in your family:

Relationship to Patient	Living/Deceased	Age	Medical Conditions
Mother			
Father			
Grandmother			
Grandfather			
Brother			
Sister			

Social History

Occupation	
Physical requirements of your job	
Marital Status	
Number of Children	

Tobacco Use		
Please Circle One		
Never	**Current**	**Former**

Amount Used	
Age Started	
Age Stopped	

Alcohol Use		
Please Circle One		
Never	**Current**	**Former**

Amount Used	
Age Started	
Age Stopped	

Recreational Drug Use		
Please Circle One		
Never	**Current**	**Former**

Amount Used	
Age Started	
Age Stopped	

Name: _____

Review of Systems

Are you ***currently*** experiencing any of the following?

(Please circle all that apply)

General	fatigue, fever, chills, body aches, weight loss, weight gain, loss of appetite
Eyes	double vision, blurred vision, peripheral vision changes, changes in vision, sudden visual loss, central vision changes, wears glasses/contacts for vision correction
Head/Ears/Nose/Throat	headaches, vertigo, lightheadedness, recent head injury, neck stiffness, neck pain, sinus problems, hearing loss, ringing in ears, hoarseness, difficulty swallowing, voice changes
Cardiovascular	chest pain, irregular heartbeats, lower extremity edema
Respiratory	shortness of breath, wheezing, cough, sleep apnea
Gastrointestinal	nausea, vomiting, diarrhea, constipation, abdominal pain, rectal incontinence
Genitourinary	incontinence, painful urination, frequent urination, urinary retention
Skin	rash, itching, new skin lesions
Neurologic	muscular weakness, incoordination, tingling/numbness, falls, memory difficulties, speech difficulties, seizures, loss of balance
Musculoskeletal	joint pain, joint swelling, muscle pain, limitation of motion, muscular weakness, muscle cramps, back pain, gait disturbance, restless legs, extremity pain
Endocrine	excessive urination, excessive thirst, nipple discharge, enlarged hands and feet, enlarged facial features
Psychiatric	anxiety, depression, hallucinations, difficulty sleeping
Hematologic	easy bleeding, easy bruising, previous blood transfusion
Allergic/Immune	sinus allergy symptoms, latex allergy

Name: _____

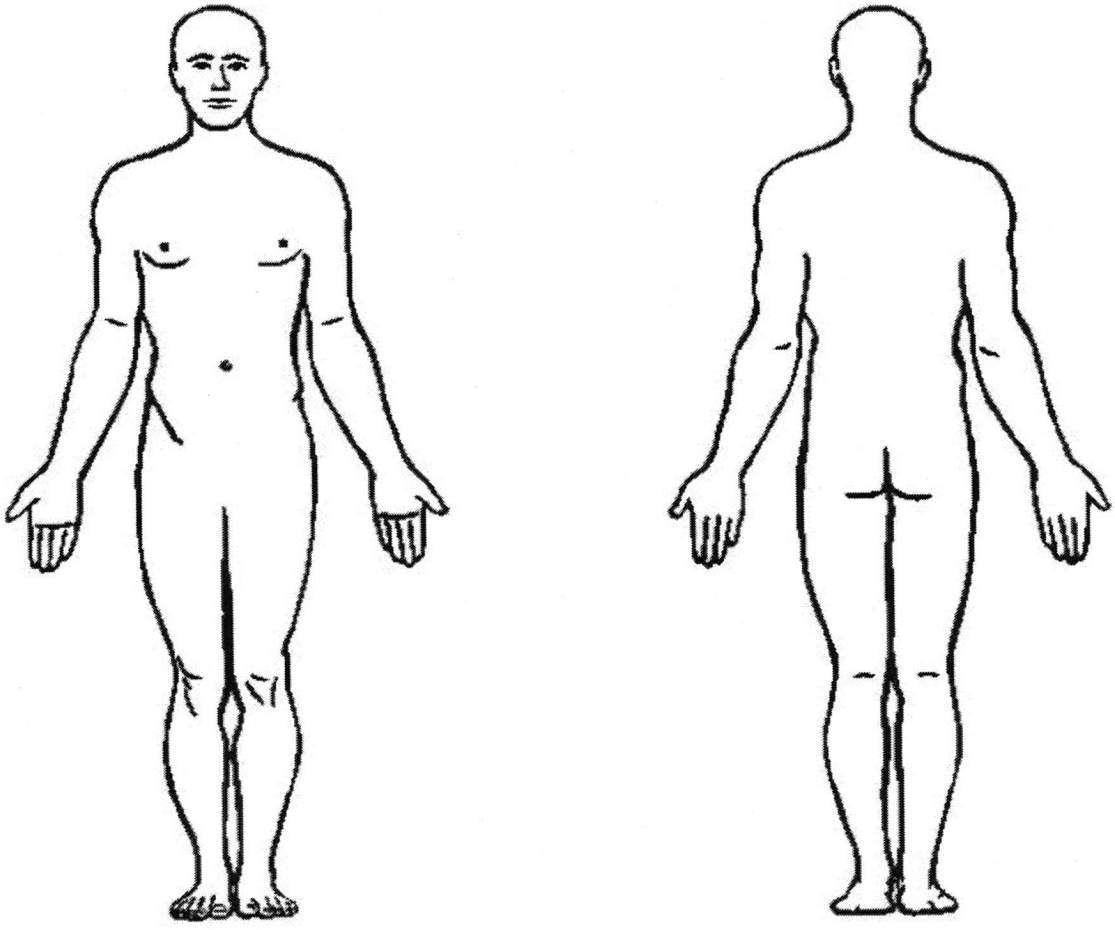
Hand Preference

Please Circle Your Hand Preference	Right	Left	Ambidextrous

Pain Diagram

Please indicate the location of the pain on the chart below using the following symbols:

Numbness _____ Burning XXXX Pins and Needles //// Aching ||||



How did you first hear about Dallas Neurosurgical?

Internet / DNS Website	
Mass Media (i.e. magazine, newspaper, radio)	
Family Member	
Friend or Colleague	
Referring physician	
Other (please describe): _____	