PATIENT INFORMATION

(PLEASE PRINT)

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY #

DATE OF BIRTH	SEX	MARITAL STATUS	PHONE #

ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER	PHONE #

BUSINESS ADDRESS	CITY	STATE	ZIP CODE

REFERING PHYSICIAN	PHONE #
PRIMARY CARE PHYSICIAN	PHONE #

REASON FOR VISIT

IS THIS RELATED TO AN ACCIDENT?		TYPE OF ACCIDENT?			DATE OF INJURY
YES	NO	AUTO	EMPLOYMENT RELATED	OTHER	

IN CASE OF EMERGENCY, CONTACT (Name of friend or relative – not living with you)

LAST NAME	FIRST NAME	MI	RELATIONSHIP

ADDRESS	CITY	STATE	ZIP CODE

HOME #	WORK #

HEALTH INSURANCE INFORMATION (Please provide copies of all insurance cards)

PRIMARY INSURANCE	POLICY #	GROUP #	PHONE #

POLICY HOLDER NAME	POLICY HOLDER DATE OF BIRTH	RELATIONSHIP

SECONDARY INSURANCE	POLICY #	GROUP #	PHONE #

POLICY HOLDER NAME	POLICY HOLDER DATE OF BIRTH	RELATIONSHIP

The above information is true to the best of my knowledge. I authorize treatment for the above- mentioned individual or myself.

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I hereby authorize Texas Spine & Neurosurgery Center, P.A. to furnish information to insurance carriers concerning my illness and treatment. I hereby assign all payments to Texas Spine & Neurosurgery Center for all medical services rendered to the above-mentioned individual or myself. I designate Texas Spine & Neurosurgery Center to be my authorized representative under ERISA. I authorize Texas Spine & Neurosurgery Center to appeal any denials of benefits and to pursue any remedies otherwise available under law, including ERISA. I understand that I am ultimately responsible for all charges and agree to pay all bills within 30 days from receipt of a statement unless other arrangements are made.

SIGNATURE_____**DATE** _____

PAYMENT POLICIES

We are committed to providing you with the best possible care. If you have medical insurance we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

PRIVATE INSURANCE: All contracted insurance companies are billed directly as a courtesy. Any remaining balance for non-covered benefits is your responsibility. Payment for this is expected within 30 days from receipt of your statement.

CO-PAYS, COINSURANCE, DEDUCTIBLES: All co-pays and/or applicable coinsurance or deductible are expected at the time the service is rendered.

REFERRALS: We make every effort to obtain referrals from your primary care physician (PCP) as required by your insurance plan. However, we encourage our patients to be proactive and call their PCP to ensure timely receipt of the referral. If we are given incorrect insurance information or are unable to obtain the necessary referral, all fees are your responsibility and must be paid in full before services are rendered.

METHOD OF PAYMENT: We accept cash, checks, Visa, MasterCard and Discover.

PAYMENT ARRANGEMENTS: We understand that there may be times when financial difficulties come upon us without warning. Our goal is to help you by keeping your account at a manageable level.
Under special circumstances short term payment arrangements may be made if approved in advance. Accounts on a short term payment plan are required to make a payment each month as defined by your payment plan. Failure to make payments according to your payment plan will result in a past due balance. Past due balances must be paid in full before any additional appointments will be scheduled.

NO SHOW/CANCELLATION POLICY: There will be a fee of $25.00 for no-show or cancellation of appointments without a 8 hours notice.

OWNERSHIP & REFERRAL DISCLOSURE: Texas Spine & Neurosurgery Center is committed to providing the highest quality of care at the most affordable costs. In carrying out our commitment of excellence, there may be times when our treatment team includes providers or facilities who are non-participating providers with your insurance plan. Texas Spine & Neurosurgery Center also has financial interests in certain service providers and facilities. To ensure that you have the necessary information to make an informed decision about your health benefits and care, we will inform you of any referral to a non-participating provider and will disclose any financial interest prior to scheduling your treatment/procedure. Your freedom of choice for providers is fully protected by state law.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Print Name:_____

Signature:_____

Date:_____

Texas Spine & Neurosurgery Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 281-313-0031.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 281-313-0031.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電
281-313-0031

PATIENT NAME:_____

MEDICAL HISTORY

GENERAL INFORMATION

NAME: _____

AGE: _____ ☐ MALE ☐ FEMALE

HT: _____ WT: _____ ☐ RIGHT-HANDED ☐ LEFT -HANDED

NAME OF FAMILY DOCTOR: _____

REASON FOR OFFICE VISIT

☐ Work Related Injury/Date of Injury_____

☐ Automobile accident/Date of Accident _____

☐ Symptoms/Date symptoms began _____

☐ Second Opinion

How would you describe your symptoms since they began?

☐ BETTER ☐ WORSE ☐ NO CHANGE

What symptoms do you have today? _____

_____

_____

Do you have urinary or fecal incontinence?

☐ NO ☐ YES

Do you have foot drop or paralysis?

☐ NO ☐ YES

Were you treated or seen at a hospital emergency room or urgent care center for this injury/illness?

☐ NO ☐ YES Where?/When? _____

Have you received further treatment for this injury/illness?

☐ NO ☐ YES

Check any of the following tests or treatments you have had for this illness or injury. (Specify when and where tests or treatments were done.)

☐ Blood tests or lab tests _____

☐ X-Rays _____

☐ CT or MRI scan _____

☐ Physical therapy _____

☐ Chiropractic care _____

☐ Epidural Steroid Injections _____

REASON FOR OFFICE VISIT (continued)

Are you able to do everything you did before the injury/illness? (Explain NO answers)

	YES	NO	
Drive	☐	☐	_____
Housework	☐	☐	_____
Yard work	☐	☐	_____
Sports	☐	☐	_____
Hobbies	☐	☐	_____
Second job	☐	☐	_____
Sex	☐	☐	_____

Have you ever seen a doctor for neck or back problems?

☐ YES If yes, specify problem, doctor, date, and any surgery. _____

☐ NO _____

MEDICATIONS

Are you taking any medications for this injury/illness, including medications from a doctor or over-the-counter medications such as aspirin, Tylenol, or Advil?

☐ YES If yes, specify medications. _____

☐ NO _____

Are you taking medications now for any other reason (including vitamins, birth control pills)?

☐ YES If yes, please complete the attached Medication List form.

☐ NO

Do you drink or eat any beverages or foods that contain caffeine?

☐ YES If yes, specify. ☐ Coffee ☐ Tea ☐ Cola ☐ Chocolate

☐ NO How much per day?_____

Have you received a flu shot since August 1, 2018? □ Yes □ No

FAMILY MEDICAL HISTORY

Has anyone in your family had any of the following conditions. (Please explain who and what they had.)

	NO	YES	
Cancer	☐	☐	_____
Heart problems	☐	☐	_____
Diabetes	☐	☐	_____
Kidney disease	☐	☐	_____
Depression/mental problems	☐	☐	_____
Alzheimer's/Memory loss	☐	☐	_____
High blood pressure	☐	☐	_____
Stroke/brain tumor/aneurysm	☐	☐	_____
Lung problems	☐	☐	_____
Parkinson's	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Other Problems	☐	☐	_____

PERSONAL MEDICAL HISTORY

Do you have a history of medical problems or surgery of the following (please explain)?

	NO	YES	
Eyes	☐	☐	_____
Ears	☐	☐	_____
Skin	☐	☐	_____
Heart	☐	☐	_____
Circulation/Blood flow	☐	☐	_____
Lungs/Asthma	☐	☐	_____
Stomach	☐	☐	_____
Bowels/Intestines	☐	☐	_____
Kidneys	☐	☐	_____
Uterus/Prostate	☐	☐	_____
Depression/Mental problems	☐	☐	_____
Arthritis/Joints	☐	☐	_____
Blood clots/other problems	☐	☐	_____
High blood pressure	☐	☐	_____
Diabetes/Thyroid	☐	☐	_____
Cancer	☐	☐	_____
Brain seizures/Epilepsy	☐	☐	_____
Headaches/Migraines	☐	☐	_____
Dizziness/Fainting	☐	☐	_____
Hepatitis	☐	☐	_____
Other problems	☐	☐	_____

Have you ever had any neck or back operation/surgery?

☐ YES When/Where? _____

☐ NO _____

Is there any reason you cannot receive blood or blood products?

☐ YES Explain. _____

☐ NO _____

Do you have any allergies (medication, iodine, tape, latex, creams, dust, food, animals, pollen, etc.)?

☐ YES Specify allergies. _____

☐ NO _____

Do you have problems falling asleep or staying asleep?

☐ YES Explain. _____

☐ NO _____

FEMALE PATIENTS

Are you pregnant? ☐ NO ☐ YES Due date?_____

Have your periods stopped? ☐NO ☐YES

Have you had your uterus and/or ovaries surgically removed? ☐NO ☐YES

Do you take hormones? ☐NO ☐YES

LIFESTYLE/SOCIAL

Do you currently use any tobacco products?

☐ YES Specify: ☐ Cigarettes ☐ Snuff ☐ Chewing Tobacco ☐ Cigars ☐ Pipe

☐ NO How much per day?_____ How many years? _____

Did you use any tobacco products in the past?

☐ YES Specify: ☐ Cigarettes ☐ Snuff ☐ Chewing Tobacco ☐ Cigars ☐ Pipe

☐ NO How much per day?_____ When did you quit? _____

Do you currently drink alcohol?

☐ YES Specify: ☐ Beer ☐ Wine ☐ Liquor

☐ NO How often do you drink?_____ How many years? _____

Did you drink alcohol in the past?

☐ YES Specify: ☐ Beer ☐ Wine ☐ Liquor

☐ NO How often did you drink?_____ When did you quit? _____

Have you ever received treatment for drug and/or alcohol problems?

☐ YES Specify when and where? _____

☐ NO _____

Indicate your marital status: ☐ Single ☐ Married ☐ Widowed ☐ Other

Do you live alone? ☐ YES ☐ NO

Do have any children? □ NO □ YES Ages:_____

Do any children live at home?_____

Do you have a relative with a physical or mental health disabilities living at home? If yes, are you the primary caregiver? ☐ NO ☐ YES Explain. _____

Do you exercise regularly? If yes, indicate the activity and how often you do it.

☐ NO ☐ YES Explain. _____

WORK INFORMATION

EMPLOYER_____ Length of employment? _____

JOB TITLE_____ How long have you done this job? _____

Does your job require you to perform the following activities:

☐	Lift_____pounds	☐	Sit	☐	Use a computer
☐	Lift over head	☐	Bend	☐	Drive a truck or forklift
☐	Reach over head	☐	Stand		

Are you working now? ☐YES ☐NO If no, how long have you been off work? _____

If you are married, does your spouse work? ☐YES ☐NO

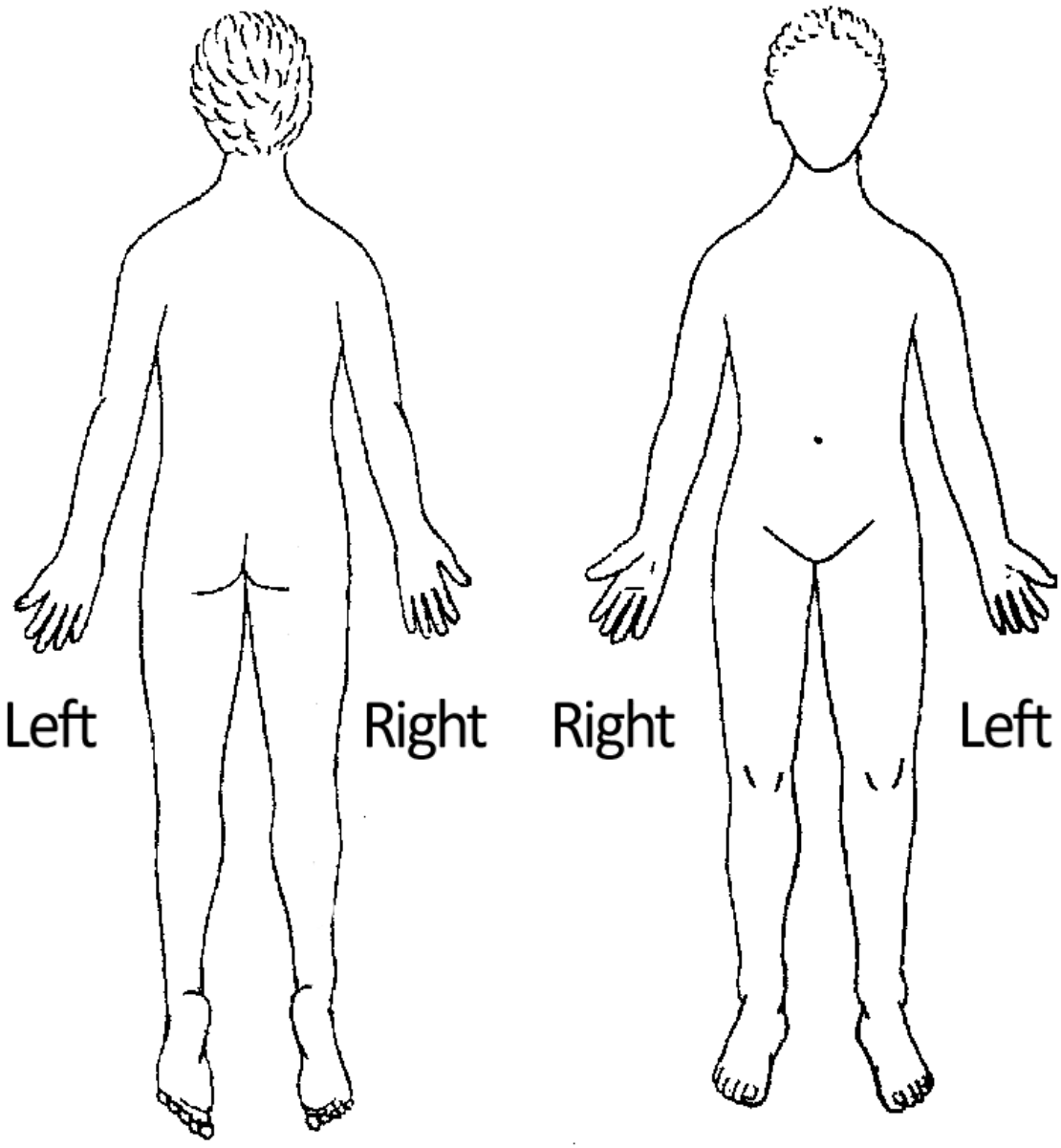
If no, how long has he/she been off work? _____

Patient's signature _____ Date _____

Name _____ **Date** _____

Using the symbols below, mark the areas on your body where you feel the described sensations. Please mark all affected areas. Please draw in your face.

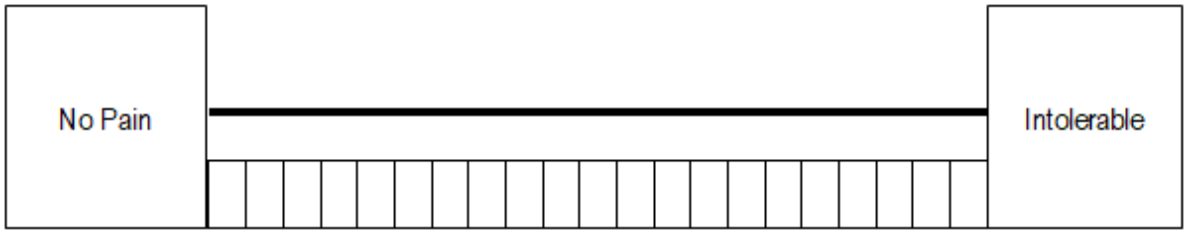
Numbness	Pins & Needles	Ache	Pain
= = = = = =	000000	xxxx	///////



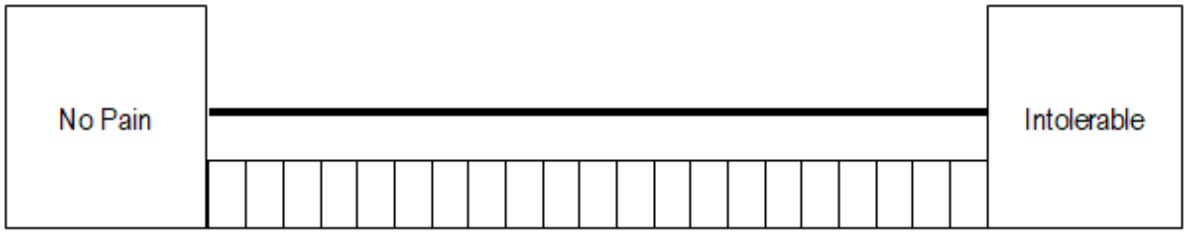
Name_____Date_____

Place an "X" in a box below the line to indicate how bad you feel your pain is today. Please mark only one box. Circle N/A if the questions isn't applicable to your pain.

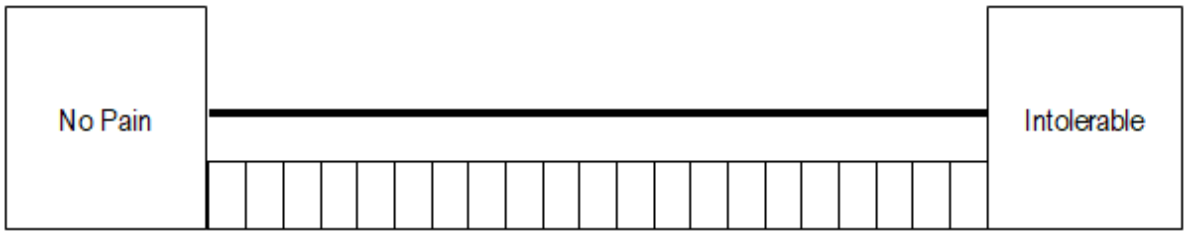
How severe is your Neck pain today? N/A



How severe is your Arm pain today? Which arm? RT LT Both N/A



How severe is your Back pain today? N/A



How severe is your Leg pain today? Which leg? RT LT Both N/A