NeurosurgicalCare

Name: _____ **Date:** _____

Health History Form

PLEASE CHECK ALL THAT APPLY.

Medical History

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fib
- ☐ Autoimmune disorder
- ☐ Blood clots
- ☐ Bowel disease
- ☐ Cancer (type): _____
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostate problems
- ☐ Reflux
- ☐ Seizure
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Other: _____

Surgical History

- ☐ Open heart surgery
- ☐ Cardiac stents
- ☐ Pacemaker
- ☐ Back surgery
- ☐ Neck surgery
- ☐ Knee surgery
- ☐ Abdominal surgery. Type: _____
- ☐ Other: _____
  _____

Family History

Mother:	☐ Alive	☐ Deceased	☐ Heart disease	☐ Diabetes	☐ Dementia
Father:	☐ Alive	☐ Deceased	☐ Heart disease	☐ Diabetes	☐ Dementia

Social History

Tobacco use:
- ☐ Never
- ☐ Current. Packs/day: ___
- ☐ Former. Quite date: _____

Alcohol use:
- ☐ None
- ☐ Rare/socially
- ☐ 1-2 drinks/day
- ☐ More than 2/day

Drug use:
- ☐ None
- ☐ Medical marijuana
- ☐ Yes
- ☐ Former

NeurosurgicalCare

Name: _____ Date: _____

Review of Systems

Neurological

Vestibular Fall & Balance

- ☐ Dizziness/vertigo
- ☐ Fall(s)
- ☐ Balance difficulty

Cognitive

- ☐ Memory problems
- ☐ Word finding difficulty
- ☐ Difficulty concentrating
- ☐ Irritability
- ☐ Sleep disturbance
- ☐ Light-headedness

Neuropathy (small nerve damage)

- ☐ Numbness or tingling in feet
- ☐ Numbness or tingling in hands
- ☐ Muscle cramps
- ☐ Heart palpitations
- ☐ Urinary difficulties
- ☐ Excessive sweating
- ☐ Blurry vision
- ☐ Bloating

Musculoskeletal

Spine

- ☐ Low back pain
- ☐ Low back & leg pain
- ☐ Neck pain
- ☐ Neck & arm pain
- ☐ Neck pain & headache
- ☐ Pain in thoracic /rib pain

Knee

- ☐ Knee pain
- ☐ Knee stiffness
- ☐ Knee swelling
- ☐ Knee buckling/locking

Other Joints

- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Ankle pain
- ☐ Elbow pain
- ☐ Wrist pain

Constitutional

- ☐ Weight changes
- ☐ Fever
- ☐ Fatigue

Ears/nose/throat

- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Difficulty swallowing

Cardiology

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Leg swelling

Gastroenterology

- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Heart burn

Genitourinary

- ☐ Urinary urgency
- ☐ Urinary frequency
- ☐ Loss of bladder control

Hematology

- ☐ Easy bruising or bleeding
- ☐ Anemia

Ophthalmology

- ☐ Loss of vision
- ☐ Double vision

Psychology

- ☐ Depressed mood
- ☐ Anxious

NeurosurgicalCare

PATIENT REGISTRATION FORM

Welcome to our practice!

Today's Date: _____/____/_____

Patient Name: _____ SSN: _____-_____-_____
Last Name First Name MI

Date of birth: ___/____/_____

Address:_____ Sex: _ Male _ Female __ Other_____

City, State, Zip: _____ Marital Status: __ Single _ Married _ Widowed

Home Phone: (____)_____-_____Cell Phone: (____)_____-_____ __ Divorced __ Separated

May we contact you at work? __ Yes __ No Work Phone: (____)_____-_____

May we leave a message containing protected health information on your __ Home Phone __ Cell Phone __ Work Phone?

Email address: _____

Please complete this section only if someone other than the patient is financially responsible. The Guarantor is the person financially responsible for this patient's bill.

Guarantor: _____ Patient's relationship to Guarantor: _____
Address: _____ SSN: _____-_____-_____
City, State, Zip: _____ Date of Birth:_____/_____/_____
Phone #: (___)_____-_____ Sex: __ Male ___ Female __ Other

Emergency Contact Information:

Name: _____ Patient's relation to Emergency Contact: _____
Phone #: (___)_____-_____ Alternate Phone# _(___)____-_____
May we discuss protected health information with your Emergency Contact? ___Yes ___No

Approval to Discuss Your Protected Health Information:

I hereby authorize Neurosurgical Care to discuss my protected health information with the following persons:
Please indicate each approved person's relation to you (sibling, child, parent, spouse, friend, attorney, etc.).

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient Signature: _____ Date: _____

Employment Information:

Employment status: __ Employed _ Retired _ Disabled _ Unemployed _ Self-employed _Active military __Student
Employer: _____ Phone #: (____)____-_____

Primary Care Physician/ Referring Physician

PCP:	Referring Physician (if different):
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone #:	Phone #:

NeurosurgicalCare

649 North Lewis Road - Suite 225
Royersford, PA 19468
Phone: 610.495.3620 -- Fax: 610.495.3623

Acknowledgement of Receipt & Acceptance of Patient Financial Policy

I hereby acknowledge that I have read and understand the Patient Financial Policy and agree to be subject to same.

I certify that the insurance information provided by me is correct.

I authorize *Neurosurgical Care ("NC")* to submit a claim to my insurer(s) for services rendered by *NC*.

I authorize *NC* to release medical and/or demographic information about me needed for this or a related claim to my insurer or its agents.

I request that the payment of authorized benefits be made on my behalf. I assign benefits payable for services rendered by NC to be paid to NC.

I understand that I am responsible for deductibles, coinsurance charges and co-payments not covered by my insurance. Should my insurance plan not provide coverage in its entirety for any reason, I understand that I may be responsible for payment.

_____ _____

Signature Date

_____

Print Name

NeurosurgicalCare

649 North Lewis Rd, Suite 225
Royersford, PA 19468
Phone: (610)-495-3620
Fax: (610)-495-3623

Please list ALL medications you are CURRENTLY taking, including dosage (i.e. 100 milligrams) and frequency (i.e. 3 times a day)

MEDICATION	DOSAGE	FREQUENCY

If ***ALLERGIC*** to any medication, list below along with the reaction that occurs when said medication is taken.

MEDICATION	REACTION

Please provide the name and phone number of the Pharmacy where your prescriptions are filled.

Pharmacy name: _____

Pharmacy phone number: _____

Patient name (printed): _____ Date: _____

Patient signature: _____