Patient's name_____ Date of Birth_____

S**treet Address POBox**_____

City_____ **State**_____ **Zip**_____

Patient's home phone # (_____) _____ **Patient's cell phone #** (_____) _____

Which phone # is your primary #? (For appointment confirmation calls, etc.) (PLEASE CHOOSE ONE) □ Home □ Cell

Social Security #_____ **Sex:** □ Male □ Female **Marital Status:** □ Single □ Married □ Divorced □ Widowed

Race: (PLEASE CHOOSE **ONLY ONE**) □ African American □ Asian □ White □ American Indian □ Other □ Declined

Ethnicity: (PLEASE CHOOSE **ONLY ONE)** □ Hispanic □ Not Hispanic □ Declined □ Other

Preferred Language □ ENGLISH □ SPANISH □ ASL □ Other_____

Emergency phone # (_____) _____ **Emergency contact's name**_____

Emergency contact's relationship_____ **Patient's e-mail address**_____

Referring physician's name/address/phone #_____

_____

Family physician's name/address/phone #_____

_____

Patient's employer_____ **Patient's employer's phone #** (_____) _____

Spouse's name_____ **Spouse's cell #** (_____) _____

Spouse's date of birth_____ **Spouse's SSN**_____

Spouse's employer_____ **Spouse's employer's phone # (**_____) _____

Primary insurance_____

Policy #_____ **Group #**_____

Patient's relationship to subscriber: □ Self □ Spouse □ Child **Subscriber's name**_____

Subscriber's date of birth_____ **Subscriber's employer**_____

Secondary insurance_____

Policy #_____ **Group #**_____

Patient's relationship to subscriber: □ Self □ Spouse □ Child **Subscriber's name** _____

Subscriber's date of birth_____ **Subscriber's employer**_____

1.* Is this a work-related injury?** □ Yes □ No **<u>If yes, please notify the receptionist****</u>**

2. Is patient 19 years of age or younger? □ Yes □ No **If yes:**

Responsible party's name_____ Responsible party's SSN_____

Patient's school_____ Grade_____

REGARDING TREATMENT: I hereby authorize the physician (s) at Neurosurgical Associates of Nebraska in charge of the care of _____ (patient's name) to administer any treatment, therapy or testing that may be deemed necessary or advisable in the diagnosis and treatment of this patient.

REGARDING PRESCRIPTION REFILLS: Telephone prescription refills must be requested Monday – Thursday between the hours of 8:30 a.m. and 5:00 p.m. Telephone prescription refills may be delayed due to the physician's necessity to review your record determining the appropriate medicine to prescribe. Also, please note that it is our belief that narcotic pain relievers are, in general, for short-term use only. These policies are in your best interest and we thank you for understanding.

AUTHORIZATION/RELEASE/ACKNOWLEDGEMENT:

- I authorize Neurosurgical Associates of Nebraska to accept assignment of benefits.
- I authorize payment of medical benefits to Neurosurgical Associates of Nebraska.
- I am responsible for co-insurance, co-payments, and/or deductibles at the time of service.
- If my insurance is non-contracted (out of network), the clinic will courtesy file the claim for services rendered.
- If I have no insurance, fees will be due at the time of service.
- A fee of $20 will be charged for all returned checks.
- If I fail to arrive or fail to cancel my appointment within 24 hours, a No Show Fee will be charged ($35 for appointments).
- All previous balances owed will be requested at the time of registration.
- Refunds will be issued for any overpayments upon request, if the total account balance is zero.
- In the event any fees for professional medical services are not paid timely, I will be legally responsible for all costs of collections, including 25% attorney's fees, court costs and legal interest.
- I authorize disclosure and/or release of any medical information necessary to process insurance forms, requested by attorneys, physicians, insurance companies, employers, health care providers, or any other entity which may be concerned with payment of charges incurred at Neurosurgical Associates of Nebraska.
- I authorize Neurosurgical Associates of Nebraska to obtain medication history via our EMR system from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment. I understand this may be revoked upon written notice, except to the extent that action has already been taken on this authorization.
- I have received a copy of Neurosurgical Associates of Nebraska (s) Notice of Privacy Practices.
- I acknowledge and agree that Neurosurgical Associates of Nebraska and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Neurosurgical Associates of Nebraska if I have given up ownership or control of any such telephone number.

_____ _____

Signature Of Patient **Date**

Alternate Communication Consent Form

Dear Patient,

By completing the consent form below, I hereby authorize Neurosurgical Associates of Nebraska to discuss my billing, diagnosis and/or medical records with the persons listed below. This consent is in effect permanently unless the clinic is notified in writing.

I give consent to my doctor and/or staff at Neurosurgical Associates of Nebraska to discuss my billing, diagnosis and or medical records with the following persons:

_____relationship_____

_____relationship_____

_____relationship_____

_____relationship_____

_____ _____

Patient signature Date of Birth

_____ _____

Date signed Witness

PATIENT MEDICAL HISTORY REVIEW

Please take the time to accurately complete this health assessment form. This information will allow us to better understand your healthcare needs. This information will be treated with strict confidentiality.

NAME _____ **DATE OF VISIT _____**

DATE OF BIRTH _____AGE_____ **Height:_____ Weight: _____**

PRIMARY CARE PHYSICIAN _____

Name of PERSON COMPLETING THE FORM (if not the patient) **(Relationship)**

PAST MEDICAL HISTORY

Medications (Include dosage and frequency)

1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

Illnesses/Injuries (Indicate past and present medical problems)

1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

Surgeries

1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

Vaccines: Influenza ☐No ☐Yes Date:_____ **Pneumonia ☐No ☐Yes Date:_____**

Allergies (List medication and type of reaction)

1. _____	5. _____	9. _____
2. _____	5. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

COMMENTS _____

FAMILY HISTORY: Please complete the following information for your relatives

	LIVING	DEAD	AGE	CHRONIC CONDITION(S)/CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS (No.__)				
SISTERS (No.__)				
SPOUSE				
CHILDREN (No. __)				

COMMENTS _____

SOCIAL AND PERSONAL HISTORY

Personal Habits: (Check all that apply)

Tobacco Product Use:

_____ Current User Type _____ Amount/day _____ Year started _____
_____ Former User Type _____ Amount/day _____ Year started _____ Stop_____
_____ Non User

_____ Caffeine consumption Amount:_____ per day/week
_____ Alcohol consumption Drink _____per day/week/month
_____ Recreational drugs Type _____ Frequency _____

Educational Level: _____
Current Occupation: _____
Exercise Habits: _____
Marital Status: ____ Single ____ Divorced ____ Separated
____ Married ____ Widowed ____ Living with partner

Children: Sons (No.) _____ Daughters (No.) _____

Last Colonoscopy (date): _____

REVIEW OF SYSTEMS (*Please check any item that describes recent or ongoing symptoms)*

General:

____ Fever
____ Chills
_____Weight loss

COMMENTS _____

Head, Eyes, Ears, Nose, Throat:

____ Double vision
____ Impaired Vision
____ Blurred vision
____ Sudden visual loss
____ Transient visual loss
____ Headaches
____ Dizziness or vertigo
____ Hearing loss
____ Ringing in ears or tinnitus
____ Difficulty swallowing
____ Hoarseness

COMMENTS _____

Cardiovascular:

____ Chest pain
____ Irregular Heart Beats
____ Rapid heart rate
____ Lightheadedness
____ History of heart attack
____ Heart murmur

COMMENTS _____

Respiratory:

____ Shortness of breath
____ Chronic cough
____ History of asthma
____ History of pneumonia
____ History of tuberculosis

COMMENTS _____

Gastrointestinal:

____ Nausea
____ Vomiting
____ Diarrhea
____ Constipation
____ Gastroesophageal reflux disease (GERD)
____ Peptic ulcer disease
____ History of hepatitis or jaundice
____ Cirrhosis

COMMENTS _____

Genitourinary:

____ Frequent, painful, or burning urination
____ Urination at night
____ Blood in urine
____ Difficulty starting or stopping urination
____ Kidney stones

COMMENTS _____

Skin:

____ Rash
____ Itching
____ Hair growth change

COMMENTS _____

Neurological:

____ Seizures
____ Episodes of loss of consciousness
____ History of significant head injury
____ Arm or leg weakness
____ Stroke

COMMENTS _____

Musculoskeletal:

____ Joint pain or swelling
____ Muscle weakness
____ Back pain
____ Recent neck injury
____ Neck pain
____ Recent back injury

COMMENTS _____

Endocrine:

____ Frequent urination
____ Unusual thirst
____ Intolerance to heat or cold

COMMENTS _____

Psychiatric:

____ Anxiety
____ Depression

*COMMENTS*_____

Lymphatic/Hematologic:

____ Easy bruisability or excessive bleeding
____ History of anemia
____ Abnormal blood clotting
____ History of receiving blood products

COMMENTS _____

Gynecological: (Women only)

Age periods started: _____ years of age
Number of pregnancies: _____
Number of births: _____
Current method of birth control (if used): _____

Frequency of periods: occur every ____ days and last ____ days
Periods: _____ regular _____ irregular
Last menstrual period (date): _____
Last Mammogram (date): _____ **Last Pap Smear (date): _____**
Menopause: _____ years of age

COMMENTS _____

****

Other health information or concerns: _____

_____

_____

Thank you for completing this medical history review.

_____ _____
Signature of patient or person filling out this form Date

Reviewed by: _____ _____
Date