AUSTIN NEURO SURGEONS

Medical Intake Form

PATIENT NAME: _____ DOB: _____ EMAIL: _____

REASON FOR VISIT: _____

PHARMACY NAME AND ADDRESS: _____

SEX: M / F Right handed / Left Handed Age: _____ Height: _____ Weight: _____

PLEASE *LIST* YOUR MEDICATIONS INCLUDING DOSAGE AND FREQUENCY HERE:
(May use back of form if more room is needed)

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE LIST ANY ALLERGIES: _____

_____

PATIENT MEDICAL HISTORY: *(Circle All That Apply)*

HEART DISEASE	HYPERTENSION	HYPOTENSION	HYPERCHOLESTEROLEMIA	HYPERLIPIDEMIA
SEIZURES	STROKE	DIABETES	CANCER	MAJOR INFECTION
ASTHMA	LUNG DISEASE	KIDNEY DISEASE	THYROID DISEASE	HEPATITIS
MIGRAINE HEADACHES	ARTHRITIS	ANEMIA	TUBERCULOSIS	HIV
GLAUCOMA	BACK TROUBLE	DEPRESSION	ANXIETY	ULCERS

LIST ANY OTHER MEDICAL CONDITIONS: _____ _____ _____

FAMILY HISTORY: *(Circle Status and Check All That Apply)*

	Status	Age	Diabetes	Hypertension	Heart Disease	Stroke	Cancer (specify)	Migraine	Unknown
Father	*Alive / Deceased*								
Mother	*Alive / Deceased*								
Brother	*Alive / Deceased*								
Sister	*Alive / Deceased*								
Son	*Alive / Deceased*								
Daughter	*Alive / Deceased*								

SURGICAL HISTORY: *(List Procedure and Date)*

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Employed / Unemployed / Disabled / Retired Occupation: _____

Tobacco Use: NEVER / PREVIOUSLY BUT QUIT / YES Packs/Day: _____

Use of Alcohol: NEVER / PREVIOUSLY BUT QUIT / YES Amount: _____

Use of "Recreational Drugs": NEVER / PREVIOUSLY BUT QUIT / YES What?_____

Marital Status: Married / Divorced / Single / Partnered / Widowed Number of Children: _____

Where do you live? (two-story home, at home alone, assisted living, etc.) _____

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REVIEW OF SYMPTOMS (please check all conditions which apply currently)

Constitutional Symptoms
- ☐ Fever
- ☐ Weight loss/gain
- ☐ Fatigue

HEENT
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Glasses
- ☐ Light Sensitivity
- ☐ Hearing Difficulty/Aid
- ☐ Ear pain
- ☐ Congestion
- ☐ Bleeding
- ☐ Sinus Infection
- ☐ Dentures
- ☐ Jaw/Tooth Pain
- ☐ Mouth Sores
- ☐ Sore Throat
- ☐ Hoarseness

Cardiovascular
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Abnormal Heart Rhythm
- ☐ Swelling of Ankles
- ☐ Pacemaker
- ☐ Blood Clot
- ☐ Use of Blood Thinners

Respiratory
- ☐ Painful Breathing
- ☐ Productive Cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Shortness of Breath

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Hiatal Hernia
- ☐ Nausea & Vomiting
- ☐ Constipation & Diarrhea
- ☐ Ulcers
- ☐ Liver/ Gallbladder Problems
- ☐ Black, Bloody Stools

Genitourinary
- ☐ Painful Urination
- ☐ Bladder Infection
- ☐ Difficult Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Sexually Transmitted Disease

Musculoskeletal
- ☐ Arthritis
- ☐ Bursitis
- ☐ Pain/Numbness
  - ☐ Shoulder
  - ☐ Arms
  - ☐ Hands
  - ☐ Elbows
  - ☐ Neck
  - ☐ Hip
  - ☐ Legs
  - ☐ Knees
  - ☐ Feet
  - ☐ Tailbone
- ☐ Poor Posture

Integumentary (skin or breast)
- ☐ Rash
- ☐ Itching
- ☐ Bruise easily
- ☐ Shingles
- ☐ Skin Cancer

Neurological
- ☐ Tremors
- ☐ Weakness/Numbness/Tingling
- ☐ Dizziness
- ☐ Loss of Coordination

Psychiatric
- ☐ Memory Loss
- ☐ Alzheimer's
- ☐ Depression
- ☐ Anxiety
- ☐ Alcoholism
- ☐ Thoughts of Suicide
- ☐ Irritability

Allergic/Immunologic
- ☐ Hay Fever
- ☐ Allergies (other than drugs)
- ☐ AIDS/HIV
- ☐ Cancer _____

Women Only
- ☐ Breast Pain
- ☐ Cramps or Backache
- ☐ Heavy Menstruation
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Lumps in Breast
- ☐ Menopause
- ☐ Painful Menstruation
- ☐ Vaginal Discharge
- ☐ Pain on Intercourse

Rate the severity of your pain 0 - 10 with 10 being the most severe pain you have ever experienced. _____

Explain when/how your pain began?

_____
_____
_____
_____
_____

What improves your pain?

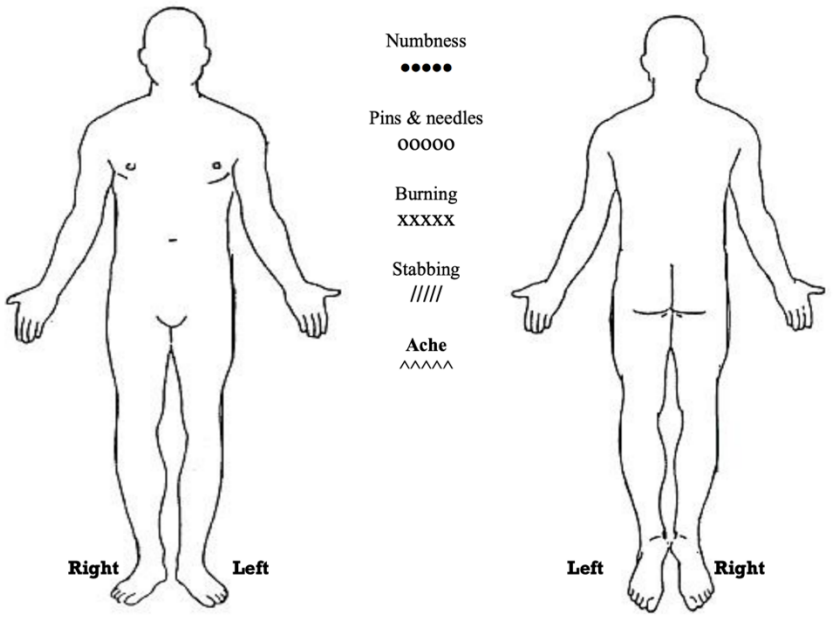
_____
_____
_____

What increases your symptoms?

_____
_____
_____

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol:



Have you had?	Any Improvement?	Date(s)	Doctor / Facility
Physical Therapy	Yes / No / Better / Worse / No Change		
Chiropractic	Yes / No / Better / Worse / No Change		
Cortisone injection	Yes / No / Better / Worse / No Change		
Corset or Brace	Yes / No / Better / Worse / No Change		
Home Exercise Program	Yes / No / Better / Worse / No Change		
Other: _____	Yes / No / Better / Worse / No Change		

AUSTIN NEUROSURGEONS

PATIENT INFORMATION SHEET

(PLEASE COMPLETE IN FULL)

Name:_____
(Last) (First) (Middle)

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

Home Phone:_____ Cell Phone:_____ Drivers License:_____

Birth Date:_____ SSN:_____ Sex: ☐ Male ☐ Female Age:_____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Pacific Islander ☐ White
☐ Black / African American ☐ Other ☐ Unknown ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Employer:_____ Work Phone:_____

Name of **Spouse** or **Parent** (Circle One):_____ DOB:_____ SSN:_____

Employer of Spouse/Parent:_____ Work Phone:_____

****E-mail:** _____ ****Preferred contact method:** ☐ **Phone** ☐ **Text** ☐ **Email**

Emergency Contact:_____Phone:_____Relation to Patient:_____

Insurance Information:

Date of Injury:_____ Work Related: ☐ **No** ☐ **Yes**

Primary Insurance Co:_____ Phone:_____

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

Name of Policyholder:_____ ID:_____ Group:_____

DOB of Policyholder:_____ SSN:_____ Relation to Patient:_____

Policyholder's Employer:_____ Phone:_____

Secondary Insurance Co:_____ Phone:_____

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

Name of Policyholder:_____ ID:_____ Group:_____

DOB of Policyholder:_____ SSN:_____ Relation to Patient:_____

Policyholder's Employer:_____ Phone:_____

How did you hear about Austin Neurosurgeons?

☐ Insurance Company ☐ Website ☐ E.R. if so which ER:_____ ☐ Friend/Family ☐ Prior Patient ☐ Other

Primary Care Physician:_____ City:_____ Phone:_____

****Referring Physician:_____ City:_____ Phone:_____**

Consent for Treatment:

I do hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

Authorization to Release Medical Information:

I hereby authorize the physician to release information in connection with my treatment to my insurance company, employer, their representative, or referring physician at such time as information is requested. I authorize assignment of benefits to my physician. Additionally, I give permission to Austin Neurosurgeons and staff to release medical information contained in my file about myself to those indicated below.

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

I have read and agree to all of the above information:

_____ _____

Patient's Signature **Date** **Guardian's Signature** **Date**

FINANCIAL POLICIES, DISCLOSURES, AND NOTICE OF PRIVACY PRACTICES

This document provides you with the financial policies, disclosures and notice of privacy practices of Austin Neurosurgeons, affiliated with Central Texas Spine Institute. We wish to ensure patients have the necessary information to make informed decisions about their medical benefits and care. A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to any of the following healthcare providers for certain healthcare services.

Consent to pay for services rendered: Copayment is required for all services at the time the services are rendered. In order to be seen by any provider you must initial and sign this form. We accept Medicare and many other commercial insurance plans. We will send your claim to your insurance company and any balance that is unpaid by your insurance company will be forwarded to you for payment. It is your responsibility to verify with your insurance plan if we are a contracted provider and to understand your coverage benefits under your policy. Please read and initial the following regarding our financial policies and disclosures

_____ I understand that I am responsible for any remaining balance not covered by my insurance company.

_____ We refer delinquent accounts to an outside collection agency. If it became necessary to refer your account to a collection agency an administrative service fee of $25.00 plus a collection fee of 30% of your balance will be assessed to your account.

_____ Our office charges a $25 administration fee for FMLA paperwork, Short-term disability paperwork, and any requests for medical records that are under 25 pages. There will be an additional charge of $.50 per page over 25 pages. Payment is due in advance and please allow 48 business hours for processing.

ATX Neuro Assist is an entity owned by Dr. Daniel Peterson that provides an assistant surgeon during your surgery. Cameron Prather, PA-C will be assisting during surgeries and will bill separately through ATX Neuro Assist.

5th Vital Healthcare is a company that provides Care Coordination services for pain management patients. Dr. Daniel Peterson is a minority shareholder in 5th Vital Healthcare.

Dr. Daniel Peterson is a minority shareholder in Arise Austin Medical Center.

Dr. Daniel Peterson is/or has been a consultant to NuVasive, Stryker Spine, Boston Scientific, Nvision Spine, Altus Spine, LDR Spine, Cerapedics, and Centinel Spine.

Accordingly, I hereby acknowledge that my attending physician has disclosed to me his affiliation with the foregoing healthcare Providers for whom, I the patient am being referred. I have also read the above stated financial policy and agree to meet my financial obligation in accordance with this policy. Additionally, I have reviewed this office's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understands that I am entitled to receive a copy of this Notice of Privacy Practices, if I so choose. I understand that I have the right to choose the providers of my healthcare services and I have the option of receiving healthcare services from any healthcare provider and/or facility that I choose.

_____
Patient Name

_____ _____
Patient Signature Date

Daniel Peterson, MD, FAANS, FACS

Austin Neurosurgeons | 3003 Bee Cave Rd. Suite #201 | Austin, TX 78746 | Phone: 512-314-3888

Patient Name: _____ Date of Birth: _____

Primary Address: _____

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I, the patient named above or his/her parent/legal representative, hereby authorize Austin Brain and Spine to:

- □ **Release my information to Daniel Peterson, MD, FAANS, FACS at Austin Neurosurgeons if you are remaining with Daniel Peterson, MD, FAANS, FACS**
- □ **OR** release my information to another entity/person (fill out name and address of other entity/person below)

Name of Entity/Person: _____

Address: _____

City, State and Zip: _____

Phone: _____ Fax: _____

Release the following individually identifiable health information for the purpose(s) identified below:

INFORMATION (CHECK ONE OR MORE)

- □ Alcohol/Substance Abuse Records (42 CFR Part 2)
- □ Billing Records
- □ Complete Medical Record
- □ Diagnostic Report
- □ Immunization Record
- □ Lab/Pathology Reports
- □ Medication List
- □ Other (Specify): _____

FOR THE PURPOSE OF (CHECK ONE AT LEAST)

- □ Continuing Care by Other Provider D Disability
- □ Insurance
- □ Legal/Attorney
- □ School
- □ Patient Request
- □ Other (Specify): _____

NOTICE TO RECIPIENT: Federal rules prohibit further disclosure by the recipient of any alcohol or substance abuse records released under this authorization unless the recipient has received written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Acknowledgments. I understand and acknowledge that:

1. Individually identifiable health information may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except psychotherapy notes), genetic testing, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.
2. I do not have to sign this authorization in that my refusal to sign will not affect my ability to receive health care services or items.
3. The entity or person receiving information under this authorization may not be subject to HIPPA or state privacy rules and the information released may no longer be protected by federal or state privacy rules.
4. I may cancel this authorization at any time by submitting a written notice of revocation to the clinic at the address listed in the upper left hand corner. The revocation will not affect any use or disclosure by the clinic before receipt of the written revocation.

EXPIRATION:

Authorization expires 180 days from the date signed or the following: _____
(Date or Event)

_____ _____ _____

Date Signature of Patient or Patient's Representative Printed Name the Patient's Representative

Relationship to Patient *(if requestor is not the patient)* □ Parent □ Legal Guardian* □ Other*: _____

* Attach Legal Document

FOR STAFF USE ONLY

Date request received: _____ Date request completed: _____ # of pages released: _____

Staff Name: _____ □ Paper Copies □ Electronic Copies