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.) ______________________________________

Medical Intake Form

AUSTIN NEURO SURGEONS

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?

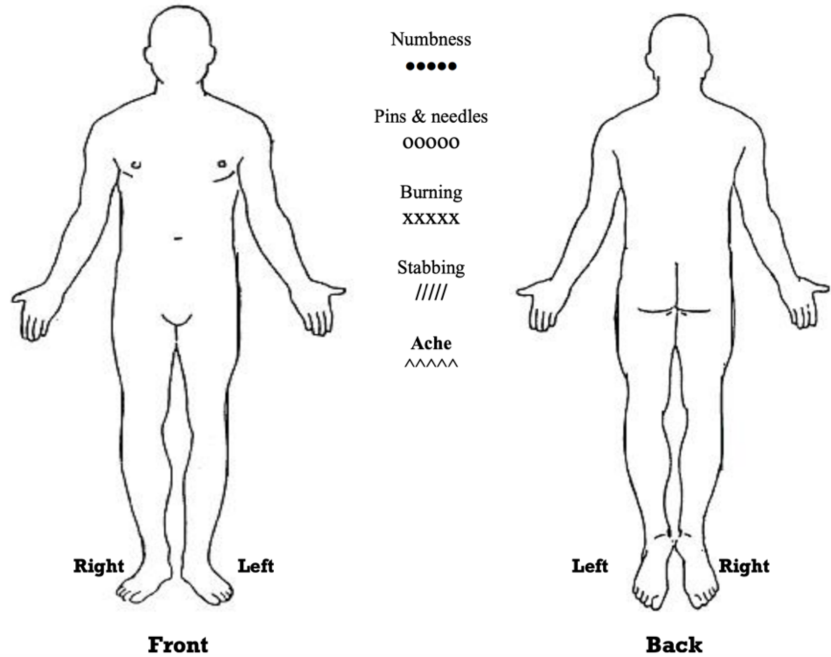
____
____
____

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 becomes 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 and out-of-network through ATX Neuro Assist.

Buffalo Neuromonitoring is an entity owned by Dr. Daniel Peterson that provides Intraoperative Monitoring during spine surgery. IOM is the application of various tests that reduce the risk of negative outcomes such as paralysis or stroke, by detecting neurological changes in the patient as they occur. The advanced detection of such medical complications allows your surgical team to act swiftly, to reverse or decrease potentially devastating neurological disabilities. This will be an out of network charge billed separately from your Physician through National Neuromonitoring Services.

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 the 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