Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

NEUROSURGICAL ASSOCIATES OF NORTH TEXAS

PATIENT NAME_____**DATE OF BIRTH**_____

PATIENT FINANCIAL AGREEMENT

1. _____**(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **NEUROSURGICAL ASSOCIATES OF NORTH TEXAS** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____**(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **NEUROSURGICAL ASSOCIATES OF NORTH TEXAS** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____**(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **NEUROSURGICAL ASSOCIATES OF NORTH TEXAS** any insurance or other third-party benefits available for health care services provided to me. I understand **NEUROSURGICAL ASSOCIATES OF NORTH TEXAS** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **NEUROSURGICAL ASSOCIATES OF NORTH TEXAS,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____**(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **NEUROSURGICAL ASSOCIATES OF NORTH TEXAS** by the Medicare or Medicaid program.

5. _____**(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **NEUROSURGICAL ASSOCIATES OF NORTH TEXAS**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **NEUROSURGICAL ASSOCIATES OF NORTH TEXAS** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **NEUROSURGICAL ASSOCIATES OF NORTH TEXAS** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____**(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse
Parent
Guarantor
Healthcare Power of Attorney

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

NEUROSURGICAL
ASSOCIATES OF NORTH TEXAS

Patient Medical History Intake Form

Symptoms and Pain Assessment

1. Chief of Complaint:

_____

2. How long have you had these symptoms?

_____ Days _____Weeks _____ Months _____ Years

3. Describe the quality of your pain. (Please **circle** all that applies)

Burning Numbness Sharp Spasms Tightness Pinprick Shooting
Stabbing Tingling Deep-Pressure Other:_____

4. How often do you experience the pain? (Please **circle** what applies)

Constant Intermittent Daily Weekly Monthly

Other:_____

5. How did your pain start? (Please **circle** what applies)

Gradually Suddenly Date: _____

Medical/Surgical History

Please *LIST* surgeries you have had:

Procedure	Date

Please *LIST* all Medication you are currently taking:

Name of Medication	Dosage/ Frequency

Allergies:_____

Latex: ___NO ___YES

Contrast: ___NO ___YES

History of Anesthesia Reactions: ___NO ___YES

If yes please explain:_____

Pharmacy Name-Address-Phone Number:_____

_____

Review of Symptoms

Do you currently have or have you in the past? (please check)

Constitutional:
___Fever
___Weight Loss
___Night Sweats
___History of Cancer
Type_____
Year diagnosed_____
___Radiation ___Chemo

Genitourinary:
___Frequent Urinary Infection
___Painful urination (dysuria)
___Blood in urine (Hematuria)
___Frequent Urination
___Incontinence
___Kidney Stones
___Prostate enlargement
___ Endometriosis

____ **Pain**
Where _____
Describe Pain _____

Eyes:
___Corrective lenses or contacts
___Lasik Surgery
___Glaucoma
___Cataracts
___Injuries or Infections

Ears, Nose, Throats, and Mouth:
___Hearing Loss
___Ear Pain
___Ear Infections
___Ringing in ears (tinnitus)
___Imbalance (vertigo)
___Nosebleed
___Sinus problems
___ Loss of Smell or Taste
___ Frequent sore throat
___Mouth sores or ulcerations

Cardiovascular:
___Chest pains (angina)
___High Blood Pressure
___Irregular pulse or atrial fib
___ Prior heart attack
___Heart Murmur
___High Cholesterol or Fats
___Swelling in feet or hands
___Leg pain/ache when walking

Respiratory:
___Asthma
___Chronic cough/Bronchitis
___ History of TB
___ History of pneumonia in the past
___Emphysema/COPD
___Shortness of breath at rest
___Short of breath with activity
___Pneumonia
___Bloody Sputum
___Pain on breathing

Musculoskeletal:
___Degenerative Arthritis
___Rheumatoid Arthritis
___Arthritis
___Frequent muscle cramps

Gastrointestinal:
___Heartburn
___Frequent Nausea
___Frequent Vomiting
___Liver Disease
___Hepatitis (A,B, or C)
___Abdominal pain
___Change in Bowel Habit
___Ulcer disease
___Gastritis
___Irritable Bowel Disease
___Diverticulitis
___ Trouble swallowing
___ Pain on swallowing
___Bloating
___ Feeling of "fullness"

Integumentary (skin):
___Psoriasis
___Breast pain/tenderness
___Nipple discharge
___Other skin disease
___ Rashes

Neurological/Psychiatric:
___Anxiety
___Depression
___Bipolar Disorder
___ Other Disorder
___ Seizures/Epilepsy
___Speech disorder/loss
___Double/Blurred Vision
___Loss of coordination
___ Disorientation/Confused
___ Prior stroke
___ Blackouts/fainting spells

Endocrine/Metabolic:
___Thyroid disease
___Diabetes Mellitus
___Anemia
___Hemophilia
___HIV/AIDS
___Immune disorder
___Other

Family History

Family	Alive	If no, age at time of death	Form what Illness	Medical Problems
Father	___yes ___no			
Mother	___yes ___no			

Family	How many total?	How many deceased	If deceased, from what illness	Medical Problems
Sibling				
Son				
Daughter				

Social History

Please Circle:

1. Marital Status: Single Married Divorced Widowed Other

2. Education Level: Grade School Jr. High High School College Post Graduate

3. Smoke Cigarettes? No Yes #packs/day?_____ For how many years_____

4. Have you quit smoking recently? No Yes How long ago?_____ #years?_____

5. Pipe/Chew tobacco/Snuff or dip? No Yes How often?_____

6. Drink Alcohol? No Yes How many drinks?_____ How often?_____

7. Use any type of recreational drugs? No Yes

If yes please explain:_____

Work History

1. Are you currently?

Employed Retired On Disability Unemployed On Sick leave Stay at home parent

2. If Employed or on Disability:

Employer:_____ Job Title:_____

How long have you work there?_____

Length of time on Job: _____ Hours/Day _____Days/Week

Patient Name:_____ DOB:_____