

Patient Intake Forms

Demographic Information

Name: _____
First Middle Last

Mailing Address: _____
[Street] [City] [State] [Zip]

[Social security number] [Date of birth]

()	()	()	()	
Cell Phone	Home Phone	Work phone	Fax	Email

Occupation / Work Name & address: _____

[Street] [City] [State] [Zip]

Emergency contact
Name & address: _____
[Phone]

[Street] [City] [State] [Zip]

Marital Status: Married/ Single/ Divorce/ Widow

Spouse's Name _____ DOB _____

Spouse's SS Number _____ Employer _____

Primary care physician & City _____

Referring doctor / individual & City _____

How did you hear about our office? _____

Medical History

Reason for visit/describe accident or injury in detail:

Date of symptom onset: _____ Date of last physical exam _____

Have you seen another specialist for this problem _____ Name _____

Systems Review (please check all that apply)

General	Neurological	Musculoskeletal	Head and Neck
<input type="checkbox"/> Fevers/ Chills	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Pain and stiffness in arms, wrists and hands	<input type="checkbox"/> Blurring, double or loss of vision
<input type="checkbox"/> Significant weight changes	<input type="checkbox"/> Headaches with vomiting	<input type="checkbox"/> Pain and stiffness in legs, knees, and feet	<input type="checkbox"/> Loss hearing/ ringing in ears
<input type="checkbox"/> Fainting/Blackouts	<input type="checkbox"/> Loss of arm/leg function	<input type="checkbox"/> Neck pain with motion	<input type="checkbox"/> Swallowing difficulty
<input type="checkbox"/> Appetite changes	<input type="checkbox"/> Loss of sensation	<input type="checkbox"/> Back pain with motion	<input type="checkbox"/> Frequent sinus infections
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Recent Loss of bowel/bladder control (incontinence)	<input type="checkbox"/> Muscle wasting and fatigue	<input type="checkbox"/> Excessive snoring
<input type="checkbox"/> Easily fatigued	<input type="checkbox"/> Tremors	<input type="checkbox"/> Arthritis	
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Frequent bone fractures	
	<input type="checkbox"/> Loss of eye/ear function		
	<input type="checkbox"/> Stroke		
Cardiovascular	Pulmonary	Gastrointestinal	Urological
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Chest pain with exertion	<input type="checkbox"/> Chronic bronchitis	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Pain with urination
<input type="checkbox"/> Chest pain with Rest	<input type="checkbox"/> Productive cough	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sex diseases
<input type="checkbox"/> Irregular heart rate	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Incontinence
<input type="checkbox"/> High/ low blood pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Rectal bleeding	
<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Liver disease	
Endocrine	Infections	Psychiatric	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis A / B / C	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Thyroid imbalance	<input type="checkbox"/> AIDS / HIV exposure	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Suicidal thoughts

Past Medical Conditions:

Please list all medical conditions and Hospitalizations over last 5 years	Years / date of onset	Medication and dosage for condition
1.		
2.		
3.		
4.		
5.		

Past Surgical procedures:

	Date	Surgeon/location
1.		
2.		
3.		
4.		
5.		

Anesthesia difficulties:

Other Prescription Medications and Dosage:

Allergies to medications: _____

Social history:

Tobacco products	Y / N	Years smoking: _____
Alcohol Products	Y/ N	Alcoholism Y/ N
Drug use:	Y/N	Injectable agents Y/N

Previous disabilities work related: _____

Family History: (check all that apply)

- | | | | | |
|-----------------------------------|--|--|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Depression/ psychiatric illness | <input type="checkbox"/> Other: _____ | _____ |

Other Members of household: (spouse / children):

INSURANCE INFORMATION-

(please fill out **and** we will need a copy of your cards front and back please)

Primary insurance:

Name and address

Phone _____

Primary person insured _____ Social security number: _____

Policy number: _____ Date of birth: _____

Group Number _____ Employer of Policy Holder _____

Secondary insurance:

Name and address

Phone _____

Primary person insured _____ Social security number: _____

Policy number: _____ Date of birth: _____

Group Number _____ Employer of Policy Holder _____

Worker's compensation claims

Insurance Carrier name and address: _____

Phone number: _____ Fax: _____ Supervisor: _____

Claim number: _____

Date of injury: _____ Last day worked full duty: _____,

Last day worked modified duty: _____ Case worker: _____

Name of person authorizing consultation with neurosurgery: _____

Employer name and address at time of injury:

Motor Vehicle accident (Please note that we do not bill auto insurance directly.)

Date of injury: _____

Insurance Company name and address:

Policy number _____ Phone _____

Case manager and phone _____

Describe in detail: _____

Attorney: _____

Phone: _____ Fax: _____

Authorizations, Payment policy and Assignments of Benefits

Physician payment benefits:

I understand that Northern Rockies Neuro-Spine provides the best Neurosurgical care possible with costs of medical services on par with all local providers and I direct my insurance company to pay Northern Rockies Neuro-Spine and /or its physician members and/or representative third party billing companies for Northern Rockies Neuro-Spine all fees associated and attributable to care rendered by any and all providers working for or in concert with Northern Rockies Neuro-Spine. I understand that claims will be submitted to primary insurers, secondary insurers and Medicare insurers and I agree to assign all benefits to Northern Rockies Neuro-Spine applicable to care rendered by the listed providers. I also understand that I am ultimately responsible for any and all bills, fees and costs associated with attorney fees required to collect for monies due Northern Rockies Neuro-Spine based upon these services rendered, and that if my insurance company (ies) fail to reimburse Northern Rockies Neuro-Spine within ninety (90) days, annual interest rate charges may accrue at 1.5% per month based upon the outstanding balance owed for these services rendered. I understand that I am responsible for all balance bills after insurance company payment(s) for these services regardless of insurance company interpretation of “usual and customary fees” assigned for the benefits I have received and that Northern Rockies Neuro-Spine will arrange and discuss payment arrangements for patient responsibility of fees at my request.

X _____
Printed name of patient or legal guardian

X _____
Signature of patient or legal guardian

Northern Rockies Neuro-Spine

Privacy Statement

Northern Rockies Neuro-Spine takes seriously the trust you place in us in providing health care for you and your family. This statement describes some of the measures we have taken and are taking to ensure our commitment to keeping your personal and medical information secure. We will protect your medical information and we will use information as necessary to perform treatment, secure payment, and to conduct healthcare operations.

Confidentiality Procedures

- We will limit the amount of information we share to the minimum required to provide a quality service to you.
 - Some of the limited information we will need to share will be with your insurance plan. We will only allow authorized employees access to your personal and medical information. Each employee also signs a confidentiality statement, which stresses the importance of safeguarding our patient's personal and medical information.
 - We will: provide necessary information to insurance companies to process claims, share appropriate information with other physicians when referred or transfer of care occurs, in the event that you request and consent to sending information to a third party, or as required by law. This information may include medical claims, medical reports, social security number, address, date of birth, and telephone number. While this list is not all-inclusive, it should give you an idea of the type of information we are referring to in this statement.
- You may write to Northern Rockies Neuro-Spine requesting to:
 - Access your records
 - Request an amendment to your information
 - Request an accounting or restriction of non routine disclosures
 - Complain about our privacy practices

Disclosure of Information

- We will disclose personal and medical information:
 - To third parties upon your written request
 - As required or permitted by law or law enforcement or for public health reasons.
 - To comply with peer review for the purpose of reviewing the service or conduct of any of our medical care professionals or our medical facility

I acknowledge that I have received a copy of Northern Rockies Neuro-Spine's Privacy Statement.

If you have any questions, would like further information, or have a dispute regarding your rights or our Privacy Practices, please contact Teresa Trier, Privacy Officer at Northern Rockies Neuro-Spine.

Name

Date

Signature

PATIENT COMMUNICATION REQUEST

To respect your privacy, please tell us how you would like us to communicate with you regarding your healthcare e.g., test results, appointment changes, surgery schedule, etc.

If you are not available to take our call, do you want us to leave a message? (Please note that if you leave this blank we will not leave any messages on any phones.)

Telephone Numbers:

Home: _____ Answering machine YES NO

Work: _____ Voice Mail YES NO

Cell Phone: _____ Voice Mail YES NO

Release of information to others:

- Northern Rockies Neuro-Spine may disclose to a family member, other relative, or a close personal friend, protected health information directly relevant to that person's involvement with your care or payment related to your care. We will also disclose protected health information to an individual if we reasonably infer from the circumstances, based on the exercise of professional judgment that you do not object to the disclosure.

- Northern Rockies Neuro-Spine may disclose protected health information to the following people only:

- Northern Rockies Neuro-Spine may only disclose my protected health information to me.

Please print patient name

Date

Patient's signature