Northwest Neurosurgery Institute

1. Name:_____ DOB: _____ SSN: _____

Address: _____City:_____State: _____Zip:_____
Home Phone: _____ Cell: _____ Gender: M☐ F☐
Work Phone: _____ Marital Status: _____

Race:
☐ American Indian or Alaska Native
☐ Asian ☐ Other Pacific Islnd'r
☐ Black or African American
☐ Native Hawaiian ☐ More than one race
☐ White ☐ Refused to answer

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Refused to answer

Preferred Language:
☐ English
☐ Spanish
☐ Other:
_____

Meaningful Use is the name of a new nationwide initiative to improve the health of our nation. As part of this initiative, Northwest Neurosurgery Institute, LLC is required to gather information for compliance with the Meaningful Use guidelines. Part of this information includes adding patients' Race, Ethnicity and Preferred Language to our electronic medical record. The government requires we gather this information to better identify possible disparities in access and quality of healthcare based on race and ethnicity on a national level. If you have additional questions please visit the Office of the National Coordinator for Health Information Technology at www.healthit.hhs.gov and search Meaningful Use.

2. Name of Policy Holder (if different from the patient): _____

Relationship: _____ DOB: _____ SSN: _____

Address (if different than above) _____

3. Name of Patient's Employer: _____

4. Emergency Contact: _____
(name, number, relationship)

5. Pharmacy (name, location/intersection, phone): _____
PLEASE NOTE: Prescription refills will only be authorized Monday – Friday, 9:00am – 5:00pm
Please Initial: _____

6. Referred by: _____

7. Primary Care Physician: _____

8. Auto Accident? Yes No (If yes, please give accident date) _____

9. Worker's Compensation? Yes No (If yes, please give injury date) _____

****Primary Insurance claims will be filed on your behalf with correct insurance information.****
****Please provide our office with a copy (front & back) of your insurance card(s).****
****Supplementary/Secondary carriers will be filed ONCE as a courtesy.****

****All HMO/POS patients are required to have a referral from our office if you are in need of another physician's services.****

Assignment & Release:
I hereby consent for Northwest Neurosurgery Institute, LLC to provide me with medical treatment.
I authorize the release of medical information contained in my chart to my, and or, the insured's insurance company, in order to process any bills. I authorize the use and disclosure of my private health information for the purpose of Treatment, Payment and Healthcare Operations. I authorize payment from my, and or, the insured's insurance company directly to Northwest Neurosurgery Institute, LLC. Should my insurance company deny or not cover charges for ANY reason, I am financially responsible for the full amount of the bill. Should my account be referred to an outside collection agency, I agree to pay the collection fees.

_____ _____
Signature of Patient (or Personal Representative) Today's Date

Northwest Neurosurgery Institute, LLC	**ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES FORM**
EFFECTIVE DATE: January 1, 2006	**REFERENCED POLICY:**NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices:

_X_ Paper

___ Electronic Mail

_____
Name of Patient

_____
Signature of Individual Acknowledging NPP

___ Patient

___ Personal Representative

___ Healthcare Surrogate

_____
Employee Witness

_____
Date

FOR OFFICE USE ONLY

This Medical Practice was unable to attain patient acknowledgment of the Notice of Privacy Practices. Please explain below circumstances of the patient's refusal to acknowledge the Notice of Privacy Practices in the section provided below.

_____

_____

_____

_____

_____ _____ _____

Name of Employee Employee Signature Date

Northwest Neurosurgery Institute

HEALTH HISTORY FORM

Welcome to our practice. Please fill out the information below to the best of your ability.

Today's Date: _____ Account: _____
Patient Name _____
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security No: _____ Sex: _____Height: _____ Weight: _____
Chief Complaint (Reason for your visit today):
_____
Date Symptoms Began_____ Is It Related To Work or Auto Accident Yes No
Primary Care Physician_____ Who Referred You? _____ Other Treating Physician(s)? _____

Past Medical History

Have you ever had any of the following? Please check all pertinent boxes:

- ☐ Aids or HIV+
- ☐ Diabetes
- ☐ Low Blood Pressure
- ☐ Smallpox
- ☐ Anemia
- ☐ Diphtheria
- ☐ Measles
- ☐ Stroke
- ☐ Arthritis
- ☐ Epilepsy/Seizures
- ☐ Migraine Headaches
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Glaucoma
- ☐ Mitral Valve Prolapse
- ☐ Tuberculosis
- ☐ Back Trouble
- ☐ Heart Disease
- ☐ Mumps
- ☐ Ulcer
- ☐ Bladder Infections
- ☐ Hemorrhoids
- ☐ Pneumonia
- ☐ Venereal Disease
- ☐ Bleeding Tendency
- ☐ Hepatitis
- ☐ Polio
- ☐ Whooping Cough
- ☐ Blood Transfusions
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Sleep Apnea
- ☐ Bronchitis
- ☐ Infectious Mono
- ☐ Scarlet Fever
- ☐ Chicken Pox
- ☐ Kidney Disease
- ☐ Other (please list) _____

Previous Hospitalization/Serious Illnesses _____
_____

Medications: (Please include non-prescription) & Herbal Supplements

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Allergies:

Medication	Reaction	Medication	Reaction

Tape Allergy? Yes No **Latex Allergy?** Yes No

Past Surgical History

Please list date, type, hospital and complications.
_____
_____

Patient Social History: (Please check the appropriate response)

Marital Status	Use of Alcohol	Use of Tobacco	Illicit Drug Use	Living Situation	Dominant Hand
Single	Never	Never	Marijuana	With Family	Right
Married	Rarely	Previously, but quit	Cocaine	With Friends	Left
Divorced	Moderate	Currently	Heroine	Alone	
Widowed	Daily	Other _____	Other _____		
Separated		Packs per day_____			

Northwest Neurosurgery Institute

Occupation_____ **Employer's Name and Phone Number** _____

Family Medical History:

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

Review of Systems: Please check the box for yes, if you have any of the below:

Constitutional Symptoms		Integumentary (Skin/Breast)		Ears/Nose/Mouth/Throat	
Bad general health lately	☐	Rash or itching	☐	Hearing loss or ringing	☐
Recent weight change	☐	Changes in skin color	☐	Earaches or drainage	☐
Fever	☐	Varicose veins	☐	Chronic sinus pain	☐
Fatigue	☐	Breast pain	☐	Nose bleeds	☐
Headaches	☐	Breast lump	☐	Bleeding gums	☐
Loss of appetite	☐		☐		☐

Eyes		Respiratory		Cardiovascular	
Eye disease or injury	☐	Chronic or frequent coughs	☐	Heart trouble	☐
Wear glasses/contact lenses	☐	Spitting up blood	☐	Chest pain or angina pectoris	☐
Blurred or double vision	☐	Wheezing	☐	Palpitations	☐
Visual loss/disturbance	☐	Shortness of breath	☐	Cold extremities	☐
	☐	Difficulty breathing	☐	Swelling in hands, feet, ankles	☐

Gastrointestinal		Genitourinary		Musculoskeletal	
Abdominal Pain	☐	Frequent urination	☐	Joint pain	☐
Nausea or vomiting	☐	Burning or painful urination	☐	Joint stiffness or swelling	☐
Frequent diarrhea	☐	Blood in urine	☐	Weakness of muscles or joints	☐
Constipation	☐	Incontinence or dribbling	☐	Muscle pain or cramps	☐
Rectal bleeding, blood in stool	☐	Female – Number of pregnancies	☐	Back pain	☐
		Female – Number of deliveries	☐		

Neurological		Psychiatric		Endocrine	
Light headed or dizzy	☐	Memory loss or confusion	☐	Excessive thirst or urination	☐
Numbness or tingling	☐	Nervousness	☐	Swollen glands in neck	☐
Tremors	☐	Depression	☐	Heat or cold intolerance	☐
Paralysis/weakness	☐	Insomnia	☐	Skin becoming dryer	☐
Unsteadiness, difficulty walking	☐	Anxiety/Panic attacks	☐		
Memory loss	☐				
Stroke	☐				
Seizures	☐				

Hematologic/Lymphatic		Allergic/Immunologic	
Slow to heal after cuts	☐	List food / environmental allergies	☐
Bleeding or bruising tendency	☐		
Anemia	☐		
Enlarged glands	☐		

Pain Questionnaire for Back and Neck Patients

Location_____

Type ☐ Burning ☐ Aching ☐ Numbness ☐ Stabbing ☐ Pins & Needles

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____

Signature of Patient or Parent of Minor Date