



1. Name: _____

SSN: _____

Address: _____

Home Phone: _____

Cell: _____

Gender: M F

Work Phone: _____

DOB: _____

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:

- 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



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 circle the appropriate response)

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



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 circle "Y" for yes, if you have any of the below:

Constitutional Symptoms	Integumentary (Skin/Breast)	Ears/Nose/Mouth/Throat
Bad general health lately	Y	Rash or itching
Recent weight change	Y	Changes in skin color
Fever	Y	Varicose veins
Fatigue	Y	Breast pain
Headaches	Y	Breast lump
Loss of appetite	Y	

Eyes	Respiratory	Cardiovascular
Eye disease or injury	Y	Chronic or frequent coughs
Wear glasses/contact lenses	Y	Spitting up blood
Blurred or double vision	Y	Wheezing
Visual loss/disturbance	Y	Shortness of breath
		Difficulty breathing

Gastrointestinal	Genitourinary	Musculoskeletal
Abdominal Pain	Y	Frequent urination
Nausea or vomiting	Y	Burning or painful urination
Frequent diarrhea	Y	Blood in urine
Constipation	Y	Incontinence or dribbling
Rectal bleeding, blood in stool	Y	Female – Number of pregnancies
		Female – Number of deliveries

Neurological	Psychiatric	Endocrine
Light headed or dizzy	Y	Memory loss or confusion
Numbness or tingling	Y	Nervousness
Tremors	Y	Depression
Paralysis/weakness	Y	Insomnia
Unsteadiness, difficulty walking	Y	Anxiety/Panic attacks
Memory loss	Y	
Stroke	Y	
Seizures	Y	

Hematologic/Lymphatic	Allergic/Immunologic
Slow to heal after cuts	Y
Bleeding or bruising tendency	Y
Anemia	Y
Enlarged glands	Y

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 _____