**GREENWALD NEUROLOGICAL SURGERY**

3155 Channing Way, Suite B

Idaho Falls, Idaho 83404

Phone 208-535-4800 Fax 208-535-4808

**UPDATED PATIENT INFORMATION:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_ Marital Status\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you here\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE:**

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holders Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE COMPANY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holders Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORKERS COMPENSATION:**

Is this a Workman’s Compensation claim? Yes\_\_\_\_\_ No\_\_\_\_\_ Claim #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work comp company name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer on date of injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster Name and phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this related to an auto accident: Yes\_\_\_\_\_\_No\_\_\_\_\_\_\_ Date of Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Automobile insurance name and Policy number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREFERRED PHARMACY:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY :**  If different from above

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If under 18 Mother and Fathers Name and Phone Numbers**:

MOM-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DAD-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE SIGN & READ BELOW**

Recognizing the inherent risks of transmission of contagious diseases, especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, Syphilis, HIV/AIDS, herpes, etc. when deemed necessary by physician. Questions should be discussed with your physician. I hereby authorized the attending physician(s) to furnish the insured’s insurance company all information which said insurance company may request. I promise to pay my account when due and if my account is referred to a collection agency or attorney for collection, I agree to pay all costs of collection. I further authorized the doctor’s office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in the doctor’s files and authorize the insurance company to accept photocopy. I release you from all legal responsibility or liability that may arise from this authorization.

**Responsible Party’s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DUE TO NEW GOVERNMENT GUIDELINES:** WE ARE REQUIRED TO ASK THE FOLLOWING QUESTIONS

The Affordable Care Act (ACA) includes several provisions aimed at eliminating health disparities in America. **Section 4302 requirement**: this implementation guidance outlines the new minimum data collection standards for race, ethnicity, sex, primary language and disability status.

*This guidance is available on the Internet at:*  <http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.shtml>

**Please answer the following questions required by the government:** (Please circle or state the following that apply)

**PREFERRED LANGUAGE**: English / Spanish / other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refuse to answer

**ETHNICITY**: Not Hispanic/Hispanic/Latino/other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refuse to answer

**RACE**: White / Hispanic/ American Indian/other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refuse to answer

**New Requirements:**  In Brief: There are new requirements for asking about race, language and smoking habits during patient registration. These questions are being asked because of new federal guidelines. T*his guidance is available on the Internet at:*  
<http://www.crozerkeystone.org/news/Publications/The-Journal/2011/june-/meaningful-use-new-requirements-for-asking-about-race-language-s/>

**Social history**: Check those that apply

***Smoking***: no ☐yes never smoked

If current: every day some days How many per day: 5 or less 6-10 11-20 21-30 30 or more

How soon after you first wake up do you smoke?  Within 5 min  6-30 min  31-60 min after 60 min

ready to quit  thinking about quitting  not ready to quit

Former smoker:  3 months 3-6 months 6-12 months 1-5 years 5-10 years more than 10 years

Have you ever been treated for **drug habits**  No Yes

***Alcohol*:** no ☐yes ☐Never had a drink (if you have never had a drink, skip to personal history)

If current: every day some days Monthly or less

How many drinks do you have on a typical day?  1-2  3-4  5-6  7-9  more than 10

How often did you have 6 or more drinks on one occasion in the past year?

never less than monthly monthly  Weekly  daily or almost daily

**Personal History:** **WEIGHT**: \_\_\_\_\_\_\_\_\_\_\_\_\_ **HEIGHT:** \_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATIONS GIVEN**:

Influenza No Yes IF YES- DATE GIVEN :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by which physician/ pharmacist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumococcal No Yes IF YES - DATE GIVEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by which physician/ pharmacist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any Surgeries/hospitalizations you have had.**

**SURGERY/INJURIES**: List them **Hospitalizations:** List them

Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_

Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_

Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_

Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_

**Have you had injections related to this visit**  No Yes If so when and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had physical therapy related to this visit** No Yes If so when and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Current Medications &**  **Over the Counter Medications:** | **MG per pill** | **How Many Pills**  **per Day** | **How Often** | **By what**  **Physician** | **What are you taking it For What?** |
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**Medication Allergies: List Additional Medical Allergies: (example - metal, food, latex)**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

**LATEX ALLERGY SCREENING**

This screening tool is intended to assist in identifying patients with a latex sensitivity if the need arises for surgery. It is not intended to be all-inclusive, for individuals who are uncertain whether they are sensitive to natural rubber latex.

1. Have you ever had a reaction to or been told by a physician that you have an allergy to any latex or natural rubber product?

Yes No

2. Have you ever had itching, swelling, hives, or trouble breathing when you use any of the following items? (Fill in the bubbles that apply)

Balloons Rubber gloves Hot water bottles Rubber bands, balls Foam pillows Rubber grips Pacifiers, teething rings Belts, bras, suspenders Condoms or birth control devices

Dental dams Erasers Face masks Elastic bandages Cuffs, elastic waistbands

Ostomy bags Urinary catheters Baby bottle nipples Other

3. Have you ever had itching, swelling, hives or trouble breathing after eating any of the following?

Bananas Avocados Kiwi Chestnuts

**FAMILY HISTORY:** Please fill in all the bubbles that apply

Father: Cancer Diabetes Heart disease Hypertension Migraine Stroke Thyroid disease None

Alive Deceased Unknown

Mother: Cancer Diabetes Heart disease Hypertension Migraine Stroke Thyroid disease none

Alive deceased unknown

**HOW MANY BROTHERS/SISTERS?** BROTHERS\_\_\_\_\_\_\_\_\_\_\_ SISTERS\_\_\_\_\_\_\_\_\_\_

Sisters: Cancer Diabetes Heart disease Hypertension Migraine Stroke Thyroid disease None

Alive Deceased Unknown

Brothers: Cancer Diabetes Heart disease Hypertension Migraine Stroke Thyroid disease None

Alive Deceased Unknown

**HOW MANY CHILDREN?** SONS: Alive\_\_\_\_\_ Deceased\_\_\_\_\_ / DAUGHTERS: Alive\_\_\_\_\_ Deceased

Do any of your Sons have, or have they had: Cancer Diabetes Heart disease Hypertension Migraine

Stroke Thyroid disease None Unknown

Do any of your Daughters have, or have they had: Cancer Diabetes Heart disease Hypertension

Migraine Stroke Thyroid disease None Unknown

**PERSONAL MEDICAL / NEUROLOGICAL HISTORY -** PLEASE FILL IN THE BUBBLES TO ALL THAT APPLY TO YOU

HYPOTHYROIDISM HYPERTHYROIDISM DIABETES STROKE BLOOD DISEASE

ANXIETY DEPRESSION ARTHRITIS HERNIA HEART DISEASE STEROID USE BLOOD CLOTS

NEUROPATHY CARDIOMYOPATHY HYPERTENSION HYPOTENSION CANCER BRIDGE THERAPY

SPONDYLOSIS SPONDYLOLISTHESIS MYELOPATHY RADICULOPATHY NECK PAIN

BACK PAIN LOW BACK PAIN COMPRESSION FRACTURE HERNIATED DISC SACROIDOSIS

ROTATOR CUFF TONSILLECTOMY

**NONE, I HAVE BEEN IN GOOD GENERAL HEALTH MOST OF MY LIFE**

**DO ANY OF THE FOLLOWING PERTAIN TO YOU?** PLEASE FILL IN THE BUBBLES TO ALL THAT APPLY TO YOU

**Brain Neck Back**

Frequent or severe headaches How many bed pillows do you use Pain in leg

Head ache go away laying down Shooting pain sensation burning / tingle in leg

Head ache go away standing up Tingle/weakness Difficulty in starting urination

Blurred Vision Muscle spasms Pain with urinating

Double Vision Pain in arms Urinate more than before

Spots before eyes Foot drop Urinate less than before

Pain behind eyes Toes numb Recurrent back pain

Any change in vision Fingers numb Muscle spasms

Dizziness on change of position

**NONE, I HAVE BEEN IN GOOD GENEREAL HEALTH MOST OF MY LIFE**