New Patient Registration Form

Patient information:

Today's Date:_____ Email: _____

Name:_____ DOB: _____

Mailing Address:_____ Age: _____

City, State, Zip:_____ SSN: _____

Phone:_____ Marital Status: M ( ) D ( ) S ( ) W ( ) Other ( )

In case of Emergency, Notify: _____ Language: _____ Race: _____

Sex: Male ( ) Female ( )

Phone: _____ PCP/Referred by: _____

Relationship to patient:_____ Phone: _____

Pharmacy _____ Address _____ Phone_____

Insurance Information

Primary Insurance:_____ Secondary Insurance: _____

ID Number:_____ ID Number: _____

Mailing Address:_____ Mailing Address: _____

City, State, Zip:_____ City, State, Zip: _____

Name/Policy Holder:_____ Name/Policy Holder: _____

SSN:_____ SSN: _____

DOB:_____ DOB: _____

Employment Information

Employer:_____ Telephone: _____

Mailing Address:_____ City, State, Zip: _____

Responsible Party Information

Name:_____ *As the responsible party, I agree that all charges that are not directly paid by the insurance company will be my responsibility*

Mailing Address: _____

City, State, Zip: _____ X _____

Responsible Party Signature

DOB:_____ Phone: _____

SSN: _____

Payment of Benefits

I authorize payment of benefits, as determined by the insurance company, directly to the physician's office. I understand that I still may be responsible for any amounts not paid by my insurance company.

Signature:_____ Date: _____

Medical Release Authorization

I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that all information on this form is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature:_____ Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name Comprehensive Neurosurgery
Address 1700 FM 544 Ste. 100
City Lewisville State TX Zip Code 75056
Phone (214) 731-0300 Fax (972) 394-4622

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Patient Name:_____

History of Present Illness: Neurosurgical Condition

What is the primary reason for your visit today?

☐Brain hemorrhage/stroke ☐Head Injury ☐Brain tumor ☐Pseudotumor Cerebri ☐Hydrocephalus ☐Shunts (VP & LP Shunts)

☐Seizures ☐Chiari Malformation ☐Another Condition: _____

When did your symptoms start? _____ **Are symptoms**: ☐ Constant ☐ Intermittent

On a scale of 1 (no symptoms) to 10 (most severe), select the number that best describes the severity of your condition.

No Symptoms Mild Severe

0 1 2 3 4 5 6 7 8 9 10

Provide details regarding associated symptoms: ☐ Patient has no symptoms to report

☐Visual Disturbances ☐Nausea ☐Vomiting ☐Seizures ☐Dizziness ☐Forgetfulness ☐Disorientation ☐Lethargy ☐Other_____

If you checked any above symptoms please describe onset of symptoms:_____

Have you seen any specialist for this condition? ☐None to report ☐Neurologist ☐Neurosurgeon ☐Other: _____

Have you been hospitalized for this condition? ☐Yes ☐No

If yes, when was you most recent hospitalization? (mm/yy) _____

What test were conducted during your most recent hospital stay? ☐None to report ☐MRI ☐CT Scan ☐EEG ☐Lumbar Puncture

☐Interventional Radiology Procedures ☐Other: _____

How was your condition managed and treated during your most recent hospital stay? ☐None to report ☐Medications

☐Observation ☐Interventional Procedures ☐Surgery ☐Other: _____

How has you condition changed since first started: _____

How has you condition been treated or managed in the past? ☐None to report ☐Medications ☐Surgical Treatment ☐Physical Therapy

☐Other: _____

History of present illness- Accident Information

Is your chief complaint the result of an accident or injury? ☐Yes ☐No If yes, what is the date of the accident/injury? _____

Where did the accident occur? _____

Have you reported it to your employer? ☐Yes ☐No

Name of Workers Compensation adjustor (if applicable): _____

Workers Compensation Claim # (if applicable): _____

Medications

☐Patient has none to report

Medication/Dose	Frequency
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History

☐Patient has none to report ☐Hearing loss ☐Memory Loss ☐Meningitis ☐Migraines ☐Seizures ☐Vertigo ☐Vision Problems
☐Bleeding Disorder ☐Cancer: _____ ☐Depression/Anxiety ☐Fibromyalgia ☐Acid Reflux ☐ADD/ADHD ☐AIDS/HIV
☐Angina ☐Alcoholism ☐Seasonal Allergies ☐Arthritis ☐Anemia ☐Asthma ☐Bipolar ☐Birth Defects ☐Congenital Heart Disease
☐Congestive Heart Failure ☐COPD ☐Diabetes Type I or II ☐Diverticulitis ☐Ear Infections ☐Eczema ☐Enlarged Prostate
☐Glaucoma ☐Gout ☐Heart Attack ☐Heart Murmur ☐Hepatitis A/B/C ☐High Blood Pressure ☐High Cholesterol ☐Infective Endocarditis
☐Irritable Bowel ☐Kidney Disease ☐Mitral Valve Prolapse ☐Pneumonia ☐Rheumatic Heart Disease ☐Sinusitis ☐Sleep Apnea
☐Tinnitus ☐Thyroid Disease ☐Tuberculosis ☐Sexually Transmitted Infections ☐Voice Hoarseness ☐Earwax ☐Other: _____

Allergies

☐Patient has none to report ☐Aspirin ☐Acetaminophen ☐Codeine ☐Erythromycin ☐Ibuprofen ☐Iodine ☐IV Contrast
☐Latex ☐Metals ☐Penicillin ☐Sulfa Drugs ☐Adhesive ☐Other: _____

Surgeries

Brain Surgery? ☐Yes ☐No If yes, what was date of surgery and what physician performed surgery? _____

Other Surgeries	**Month/Year**
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Spine Conditions:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Brain Conditions:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Brain Tumor:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Neurological Disorders:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Spine Tumor:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Seizures:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Deceased:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Blood Disorders:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Cancer:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
COPD:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Dementia:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Depression:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Epilepsy:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Psychiatric disorders:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Stroke:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Seasonal allergies:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Aneurysm:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Arthritis:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Asthma:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Diabetes:	☐Father	☐Mother	☐Sibling	☐Children	☐Other
Digestive problems:	☐Father	☐Mother	☐Sibling	☐Children	☐Other

Drug/Alcohol abuse:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Emphysema:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Genetic disorders:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Heart problems:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Hepatitis:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
HIV:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Hypertension:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Kidney disease:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Lipids:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Liver problems:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Memory Loss:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Multiple Sclerosis:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Muscle weakness:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Thyroid disease:	☐Father ☐Mother ☐Sibling ☐Children ☐Other
Tuberculosis:	☐Father ☐Mother ☐Sibling ☐Children ☐Other

Patient Social History

Who lives with you at home? ☐Patient has none to report ☐Spouse ☐Children ☐Parents ☐Significant Other ☐Relative ☐Other _____

How many alcoholic drinks do you consume in a week? _____

Do you smoke? ☐Yes ☐No **If yes, how many do you smoke per day?** _____

If you quit smoking, how long ago? _____

Do you use recreational drugs? ☐Yes ☐No

Specifically, do you use any of the following? ☐None to report ☐Marijuana ☐Cocaine ☐Heroin ☐Non-prescribed narcotics ☐Other: _____

Review of Systems

General: ☐Patient has none to report ☐Fever ☐Fatigue ☐Weight Loss ☐Weight Gain ☐Other:

Allergic/Immunologic: ☐Patient has none to report ☐Stuffy nose ☐Recent Skin Rash ☐Itchy Eyes ☐Other:

Bladder/Kidney/Liver: ☐Patient has none to report ☐Blood in Urine ☐Difficulty Urinating ☐Urinary Incontinence ☐Incontinence of stool ☐Hepatitis ☐Other:

Cardiovascular: ☐Patient has none to report ☐Chest Pain ☐High Blood Pressure ☐Palpitations ☐Swelling in Extremities ☐Other:

Digestive: ☐Patient has none to report ☐Heartburn ☐Vomiting ☐Constipation ☐Diarrhea ☐Black Stools ☐Other:

Head/Ears/Nose/Throat: ☐Patient has none to report ☐Ringing in Ears ☐Hearing Loss ☐Sinus Pain ☐Sore Throat ☐Nose Bleed ☐Glaucoma ☐Other:

Hematologic: ☐Patient has none to report ☐Blood Clots ☐Unusual Bleeding ☐Recent Bruising ☐Other:

Musculoskeletal: ☐Patient has none to report ☐Back Pain ☐Neck Pain ☐Muscle Pain ☐Joint Pain ☐Joint Swelling ☐Other:

Neurological: ☐Patient has none to report ☐Dizziness ☐Hallucinations ☐Headaches ☐Memory Loss ☐Tremors ☐Nausea ☐Seizures ☐Psychiatric Problems ☐Loss of Smell ☐Tingling/Numbness ☐Stroke ☐Vertigo ☐Gait Difficulties ☐Weakness in Extremities ☐Other:

Psychiatric: ☐Patient has none to report ☐Depression ☐Anxiety ☐Other:

Respiratory: ☐Patient has none to report ☐Shortness of Breath ☐Wheezing ☐Asthma ☐Cold ☐Other:

Skin: ☐Patient has none to report ☐Skin Cancer ☐Lumps ☐Moles ☐Other:

Height: **Weight:**