Name:____ **Who referred you:**_______________

(Last Name) (First Name) (MI)

Date of Birth: _____/_____/_____ **Sex:** Male Female **SSN #:** ________-________-_________

Mon Day Year XXX XX XXXX

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Nat Hawaiian/Pacific Islander ☐White ☐Other

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other **Primary Language:**________________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino **Email:**________________________________

Home Address: ____

(Street Number and Name) (Apt #)

City:_________________________________ State: _______ Zip Code: _________________

Home Phone:_____________________________ Cell Phone: _____________________________

Primary Doctor: ___________________________ Primary Doctor Phone #:__________________________________

Pharmacy:____ **Phone #:**____

Responsible Party Information Relation to Patient: Self Spouse Parent Other

Name:______________________________ ___________________________________ ________

(Last Name) (First Name) (MI)

Date of Birth: _____/_____/_____ SSN #: _________-_________-___________

MO DAY YEAR XXX XX XXXX

Home Address: ____

(Street Number and Name) (Apt #)

City:___________________________ State:_________ Zip Code:__________________

Home Phone:______________________ Cell Phone: _________________________________

Occupation: ___________________________ Employer: __________________________________

Employer Address:____

(Street Address, City, State, Zip)

Emergency Information

In case of emergency notify:____

(Name) (Relation)

Home Address:____

(Street Address, City, State, Zip)

Home Phone:______________________ Cell Phone:______________________

Insurance Information **Please provide your current insurance card**

PRIMARY INSURANCE

Insurance Name:___________________________

Policy ID #:______________________________

Group #:________________________________

Cardholders Name:_________________________

DOB:_______________ SSN:_________________

Relation to Patient:_________________________

SECONDARY INSURANCE

Insurance Name:___________________________

Policy ID #:______________________________

Group #:________________________________

Cardholders Name:_________________________

DOB:_____________ SSN:___________________

Relation to Patient:_________________________

I hereby certify the above information is true and correct to the best of my knowledge. I understand the while Comprehensive Neurosurgery contracts with many insurance companies, it is my responsibility to verify with my plan that Comprehensive Neurosurgery is a participating provider. It is also my responsibility to find out what my coverage options and benefits are with my insurance plan. I hereby authorize Comprehensive Neurosurgery to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines.

Print Name:_____________________________________ **Date:**___________________

Signature:_____________________________________

Authorization to release medical information:

I, _________________________________, do hereby authorize Comprehensive Neurosurgery to release any medical information including but not limited to, treatment notes, laboratory results, and medical billing information, to the following person(s) listed below.

Name: ___________________________________ Relationship: ____________________________

Name: ____________________________________ Relationship: ____________________________

Name: ____________________________________ Relationship: ____________________________

Name: ____________________________________ Relationship: ____________________________

Name: ____________________________________ Relationship: ____________________________

I do understand that I am responsible for filling out a new form if any of this information needs to be changed.

☐ Please check this box if you do **NOT** want any person to receive your medical information.

Print Patient name: _____________________________________ Date: ______________________

Patient Signature: ______________________________________

Patient Authorization

Notice of Privacy Practices:

Your name and signature below indicate that you have received/been offered a copy of the Comprehensive Neurosurgery Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in the Comprehensive Neurosurgery Notice of Privacy Practices, please ask for the office manager.

Medical Care/Treatment Financial Policy:

If Comprehensive Neurosurgery has a contract with your health insurance company, we will file today's charges with that insurance company. You will be responsible for your co-payment, coinsurance and/or deductible, and the cost of any services not covered by your insurance. You may receive a bill from Comprehensive Neurosurgery for any unpaid balance. If you do not have health insurance, or Comprehensive Neurosurgery does not have a direct contract with your health plan, you will be required to pay your visit in full at the time services are rendered. You can expect to pay an initial payment for medical services, based on the cost of the basic exam, which will be collected at check-in. you will be given further information on our cash pay rates.

Release of Medical Records, Assignment of Benefits, Financial Responsibility:

I authorize Comprehensive Neurosurgery to submit claims to my insurance company as well as medical records to evaluate these claims for payment. I further understand payment of benefits, otherwise payable to me, to be made payable to Comprehensive Neurosurgery. I understand that I am financially responsible for all charges not covered by my insurance company.

Consent for Medical Treatment:

I give permission to Comprehensive Neurosurgery to perform the medical process, treatment and/or procedure that the physician and other non-physician providers and assistants may deem to be necessary. I authorize Comprehensive Neurosurgery to release any information obtained during my examination and/or treatment to my health care insurer or other payer.

Signature of Patient/Guardian:_______________________________ **Date**:___________________________

Print Name:____ **DOB:** ___________________________

PHYSICIAN OWNERSHIP DISCLOSURE

To further our commitment to the quality of medical and surgical care for our patients, we have chosen to be an owner with the following facilities/entities listed below. We believe our ownership enhances our ability to direct the way your care is delivered.

- **Comprehensive Associates of Texas, PLLC**
- **Lonestar Surgery Center**
- **Star Medical Center**

We welcome you as a patient and we value our relationship with you. Therefore, we are providing this information to help you make an informed decision about your healthcare.

You have the right to choose your healthcare provider. Should this be a concern to you, we would be happy to answer any questions you may have, including the option of selecting an alternative facility that we don't have a vested interest in. A list of alternative facilities is available upon request.

By signing below, you acknowledge that you have read and understand this notice, and that you are aware of our ownership interest in the above facilities/entities. Should we use one of the facilities/entities or should you be referred to another physician who holds an ownership interest in one of the above facilities/entities, you understand you have the option to have your healthcare services provided by an alternative facility/entity or by another healthcare provider.

You further acknowledge that you signed this notice prior to receiving services from me at an of the above facilities and prior to any referral we may do for you to another physician for specialized medical services.

__________________________________ ____

Print Patient Name Patient Signature

____

Date

COMPREHENSIVE NEUROSURGERY

Dr. Michael Turner MD, PhD

New Patient - Spine Health History

Patient Name (Print) ___________________ DOB _________ Referred by _________ Today's Date ______

1. Where is your pain? ___Neck (see 1a.) ____Low Back (see 1b.) ____Neck and Back pain (see 1a. and 1b.)

<u>1a. IF NECK PAIN</u>

Most of my pain is in my neck: ___
Most of my pain is in my right/left/both arms: __
!!!!!!My pain is equally in my neck & arms: ____

I have also experienced:
__ Hand/arm numbness and tingling
__ Hand/arm weakness
__ Hand/arm clumsiness
__ Headaches
__ Problems with gait/walking/balance
__ Problems with handwriting
__ Frequently dropping items
__ Loss of bladder/bowel control

<u>1b. IF LOW BACK PAIN</u>

Most of my pain is in my lower back: ___
Most of my pain is in my right/left/both leg: __
!!!!!!My pain is equally in my lower back and legs: ____

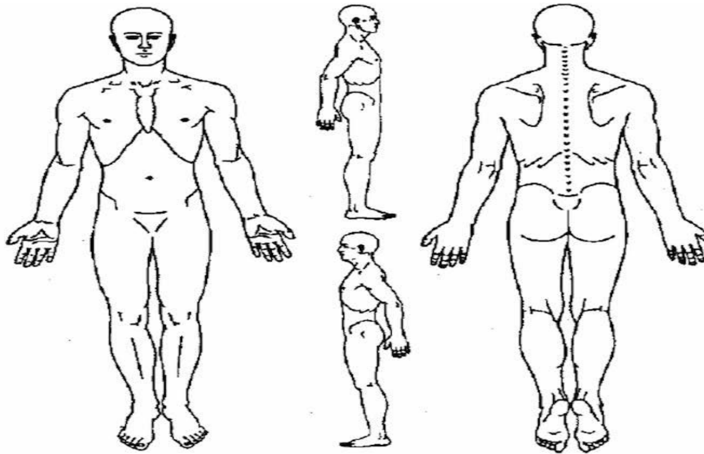
I have also experienced:
__ Leg/foot numbness and tingling
__ Leg/foot weakness
__ Leg/foot clumsiness
__ Frequent falls
__ Problems with gait/walking/balance
__ Loss of bladder/bowel control

2.

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



On a scale from 0 to 10, with 0 being none and 10 being unbearable, please mark your level of pain/discomfort for each of these areas by placing an "x" in the box of the best answer.
(Mark only one box for each scale)

____ Neck Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

____ Right Arm Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

____ Left Arm Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

____ Back Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

____ Right Leg Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

____ Left Leg Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

Office Use Only:
Radiation of Pain: Back vs. Leg (%):
Neck vs. Arm (%):

Please describe characteristics of your pain:

- ☐ Intermittent
- ☐ Constant
- ☐ Burning
- ☐ Dull
- ☐ Sharp
- ☐ Stabbing
- ☐ Throbbing
- ☐ Aching
- ☐ Cramping

Your symptoms worsen with:

- ☐ Sitting/Driving
- ☐ Standing
- ☐ Walking
- ☐ Laying down

Your symptoms improve by:

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Laying down

Please rate your pain
On a bad day ____ (0-10)
On a good day ___ (0-10)

New Patient – Spine Health History

3. ONSET:

When did your symptoms first start?__________

Was the onset _____Suddenly ____Gradually ____ unknown

What caused your symptoms? (Circle One) Injury don't know other:_______________

If an injury, where did it take place?

___Home ___School ___Sports ___Motor Vehicle Accident (see 3a.) ___Work Related (see 3b.)

3a. **If your condition is due to a motor vehicle accident answer the questions below:**

____

- Date of injury: _____________
- Do you have an attorney representing you? ___ Yes ___ No
- If Yes, name of attorney: __________________________
- Where were you when the accident happened? ___ Passenger ___ Driver ___ Pedestrian

3b. **If your condition is due to a work accident or injury answer the questions below:**

- Name of the employer where the work injury or accident occurred: ___________________________________
- Date of injury: _____________
- Do you have an attorney representing you? ___ Yes ___ No
- If Yes, name of attorney: __________________________

4. Previous Treatment for this Problem

Injections: Yes or No	**Location of injection, Type, & Times**	**How many injections in the last year?**	**Date of most recent injections**	**Helped or not?**
Physical therapy : Yes or No	**Part of body, e.g. neck, back or others**	**How many sessions/weeks**	**Date of most recent PT?**	**Helped or not?**
Chiropractor: Yes or No	**Part of body, e.g. neck, back or others**	**How many sessions/weeks**	**Date of most recent treatment**	**Helped or not**
Narcotics or other pain killers	**Discontinued? (Yes/No)**	**Dose (how much each time)**	**Frequency (how many times a day)**	**Helped or not?**
Hydrocodone				
Norco				
Tylenol with codeine				
Tramadol				
Other				
NSAIDs (Ibuprofen, Aleve, Advil et al) list name of meds below	**Discontinued? (Yes /No)**	**Dose (how much each time)**	**Frequency (how many times a day)**	**Helped or not?**

Other treatments: _____ Acupuncture _____ Exercise _____Massage _______ Brace

New Patient - Spine Health History

5. Medication List: List all tablets, patches, drops, ointments, injections etc. Include prescription, over-the-counter, herbal, vitamin, diet supplements etc.

Medication	Dose	How often you take the medication	Reason for taking	Date started	Prescriber

Height:	Known Drug Allergies:
Weight:	

6. Past Medical History: Please select all that apply (past and present)

- ❑ AIDS or positive HIV
- ❑ Arthritis
- ❑ Bleeding Disorder
- ❑ Cancer (type) _____________
- ❑ Enlarged prostate/urine flow problem
- ❑ Gallbladder problems
- ❑ High cholesterol
- ❑ Herpes
- ❑ Kidney/bladder infection
- ❑ Liver disease/Hepatitis
- ❑ Neuropathy
- ❑ Peripheral Vascular Disease
- ❑ Stroke/TIA
- ❑ Sexually transmitted disease
- ❑ Tuberculosis
- ❑ Anemia
- ❑ Asthma
- ❑ Blood clots in legs/lungs
- ❑ Coronary Artery Diseases
- ❑ Diabetes (type) _____________
- ❑ Heart attack
- ❑ Heart problems
- ❑ Kidney failure
- ❑ Lung diseases
- ❑ Migraine
- ❑ Osteoporosis
- ❑ Rheumatoid arthritis
- ❑ Sickle cell disease
- ❑ Sepsis
- ❑ Ulcers/GI bleeding
- ❑ Anxiety/Depression
- ❑ Addictive disorders (drugs/alcohol)
- ❑ Blood transfusion
- ❑ Chronic pulmonary disease (COPD)
- ❑ Gout
- ❑ High blood pressure
- ❑ Hernia
- ❑ Kidney stones
- ❑ Lupus
- ❑ MRSA infection of skin
- ❑ Pacemaker
- ❑ Seizures/epilepsy
- ❑ Sleep Apnea
- ❑ Thyroid disease

Other medical conditions (please list):

7. Surgical History: Please list all surgeries and hospitalizations you have had and the year they took place.

Type of Surgery	Name of Hospital	Surgery Date	Surgeon's name

Have you had any anesthetic problems:

____ Difficulty inserting breathing tube

____ Significant nausea or vomiting after surgery

_____ High fever during or after anesthesia

_____ Difficulty waking up after anesthesia

New Patient – Spine Health History

8. Family History: Please circle any health problems diagnosed

Condition		Condition		Condition	
Deceased:	☐Father ☐Mother	Dementia:	☐Father ☐Mother	Heart Problems:	☐Father ☐Mother
Spine Conditions:	☐Father ☐Mother	Stroke:	☐Father ☐Mother	Hepatitis A or B:	☐Father ☐Mother
Hydrocephalus:	☐Father ☐Mother	Aneurysm:	☐Father ☐Mother	HIV:	☐Father ☐Mother
Brain Tumor:	☐Father ☐Mother	Arthritis:	☐Father ☐Mother	Kidney Disease:	☐Father ☐Mother
Neurological Disorder:	☐Father ☐Mother	Asthma:	☐Father ☐Mother	Lipids:	☐Father ☐Mother
Spine Tumor:	☐Father ☐Mother	Diabetes I or II:	☐Father ☐Mother	Liver Problems:	☐Father ☐Mother
Seizures:	☐Father ☐Mother	Digestive Problems:	☐Father ☐Mother	Multiple Sclerosis:	☐Father ☐Mother
Cancer:	☐Father ☐Mother	Drug/Alcohol Abuse:	☐Father ☐Mother	Muscle Weakness:	☐Father ☐Mother
COPD/Emphysema:	☐Father ☐Mother	Genetic Disorder:	☐Father ☐Mother	Thyroid Disease:	☐Father ☐Mother

Living situation (home or nursing facility)? _______________

Do you use tobacco? ____Yes ____ No If yes, how often? ________________________________

Do you drink alcohol? ____Yes ____ No If yes, how often? ________________________________

Recreational drug use? ____Yes ____ No If yes, what type? ________________________________

10. Review of System:
In the past month, have you had any of the following problems?

General
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night Sweats

Cardiovascular
- ❑ Chest Pain
- ❑ Palpitations/irregular heartbeats
- ❑ Problems with Circulation

Respiratory
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ Cough

Eyes
- ❑ Pain
- ❑ Double or Blurred Vision
- ❑ Contact lens
- ❑ Redness
- ❑ Loss of Vision

Genitourinary
- ❑ Frequent or Painful Urination
- ❑ Blood in Urine
- ❑ Incontinence
- ❑ Frequent UTI
- ❑ Date of last menstrual period_______

Neurological
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or Loss of Consciousness
- ❑ Numbness or Tingling
- ❑ Memory Loss
- ❑ Dementia
- ❑ Tremor

Gastrointestinal
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Yellow Jaundice
- ❑ Increasing Constipation
- ❑ Persistent Diarrhea
- ❑ Blood in Stools
- ❑ Black Stools

ENT
- ❑ Ringing in Ears
- ❑ Loss of Hearing
- ❑ Frequent Sore Throats
- ❑ Hoarseness
- ❑ Difficulty in Swallowing
- ❑ Denture
- ❑ Pain in Jaw

Muscle/Joints/Bones
- ❑ Numbness
- ❑ Joint Pain
- ❑ Muscle Weakness
- ❑ Limb Swelling
- ❑ Joint Swelling
- ❑ Limb Stiffness
- ❑ Limb cramps

Hematology/Lymphatic
- ❑ Bleeding tendencies/bruising
- ❑ Frequent nose bleeds
- ❑ Enlarged lymph nodes

Psychiatric
- ❑ Depression
- ❑ Anxiety

Integumentary/Skin
- ❑ Redness
- ❑ Rash
- ❑ Nodules/Bumps
- ❑ Rash