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

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:**