Methodist
BRAIN AND SPINE INSTITUTE

Patient's Name _____

Date of Birth _____

PATIENT INFORMATION

(Please Print)

Co-Pay $_____ Workers Comp: ☐ Yes ☐ No

Name: _____ Date of Birth: _____ Age: _____
(Last) (First) (Initial)

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Ethnicity: ☐ Hispanic ☐ Latino ☐ Not Hispanic or Latino

E-mail Address: _____ Soc. Sec. #: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Person: _____ Relation: _____ Phone: _____

Referring Doctor: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Cardiologist: _____ Phone: _____

Pharmacy Name: _____ Location: _____ Phone: _____

Billing Information

Primary Insurance Company: _____ Policy #: _____ Group #: _____

Primary Insured Name: _____ Relationship to Patient: _____ DOB: _____

Secondary Insurance Company: _____ Policy #: _____ Group #: _____

Primary Insured Name: _____ Relationship to Patient: _____ DOB: _____

Methodist
BRAIN AND SPINE INSTITUTE

Authorization to Release Information

In order to protect your privacy under HIPAA, we have created this consent form for releasing medical information about you, for treatment, payment, and health care operations, or to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the mentioned phone numbers. Many times we have patient's family members call requesting medical information and legally we are not allowed to release that information without the patient's written consent. The purpose of this document is to protect your privacy.

I, _____, authorize Methodist Moody Brain and Spine Institute (MMBSI) to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party for purpose of obtaining payment on account of MMBSI, (2) the disability insurance company to expedite my claim (3) any other person(s) or entities financially responsible for the patient's care or treatment, and (4) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable disease such as Acquired Immune Deficiency Syndrome ("AIDS"). I also authorize the release of information and/or review of patient's records for purpose of conducting medical audits, utilization reviews, or quality assurance reviews.

I hereby give my permission for the release of medical information regarding appointment and questions about my condition and treatments to the following person(s):

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Do you have an Advance Directive? Living Will? (Please circle) Yes or No

Consent and Agreement: I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information.

_____ _____

Signature of Patient or Guardian Date

Methodist
BRAIN AND SPINE INSTITUTE

Assignment of Benefits

1. **Assignment of Benefits:**
Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID PRIOR TO EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees for costs of collection.

I understand that I am responsible for providing **METHODIST MOODY BRAIN AND SPINE INSTITUTE** all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **METHODIST MOODY BRAIN AND SPINE INSTITUTE.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignees to release all information necessary to secure payment.

2. **Medicare / Medicaid Assignment of Benefits: (Does not apply if you DO NOT have Medicare or Medicaid)**
   a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

Initial _____

   b. I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made.

Initial _____

_____ _____
Signature of Patient or Guardian (and relationship if not patient) Date

_____ [ ] Patient under 18 years of age
Witness

_____ _____
Translator (Print Name) Translator (Signature)

Methodist
BRAIN AND SPINE INSTITUTE

Patient's Name _____

Date of Birth _____

General:

Gender: ☐ Male ☐ Female (☐ Pregnant?)

Age: _____

Race: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian
☐ Latino ☐ Non Hispanic or Latino

Hand: ☐ Right Handed ☐ Left Handed

Do you have an Advance Directive? Living Will? ☐ Yes ☐ No

What tests or studies have you had?

☐ None
☐ X-Rays ☐ MRI
☐ Physical Therapy ☐ EMG
☐ Injections
☐ CT Scan
☐ Others _____

History of Present Illness:

Chief Complaint: (Reason for today's visit)

Location of Pain / Problem:

☐ Head Pain	○ Right	○ Left	○ Both
☐ Neck Pain	○ Right	○ Left	○ Both
☐ Arm	○ Right	○ Left	○ Both
☐ Back Pain	○ Right	○ Left	○ Both
☐ Leg	○ Right	○ Left	○ Both
☐ Hip	○ Right	○ Left	○ Both
☐ Buttock	○ Right	○ Left	○ Both

How long have you had pain in this location? _____ hrs _____ days _____ months _____ years

Please indicate the severity of your pain / problem:

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No pain Moderate Pain Worst Possible Pain

Please check if any of the following are applicable

☐ Worse in the Morning ☐ Better in the Morning ☐ Worse at Night ☐ Better at Night
☐ Worse with Activity ☐ Better with Activity
☐ Worse Sitting ☐ Worse Standing ☐ Worse Walking ☐ Comes and goes
☐ Better when treated with Medications ☐ Same or Worse when treated with Medications
☐ Dizziness ☐ Headaches ☐ Locking ☐ Radiating Pain ☐ Stabbing Pain
☐ Lasts for a short period of time ☐ Lasts for a long period of time
☐ Wakefulness at Night ☐ Sleepy and Lethargic During the Day

Please explain in more detail your history of present illness

Methodist
BRAIN AND SPINE INSTITUTE

Patient's Name _____

Date of Birth _____

Patient History	☐ Alcoholism	☐ Depression	☐ High Cholesterol	☐ Migraine	☐ Stroke
	☐ Anemia	☐ Diabetes	☐ HIV / AIDS	☐ Osteoporosis	☐ Thyroid Disease
	☐ Arthritis / Gout	☐ Glaucoma	☐ Hypertension	☐ Rheumatoid Disease	☐ Tuberculosis
	☐ Asthma	☐ Heart Disease	☐ Kidney Disease	☐ Seizures	☐ Ulcers
	☐ Cancer	☐ Hepatitis	☐ Mental Illness	☐ Other	

Medications: ☐ None

List all medications (prescription, over the counter, herbal, etc.)

Medication	Dose	Frequency	Reason

Medication Allergies: ☐ None

MEDICATION	REACTION
Anesthetic	☐ Rash ☐ Nausea ☐ Diarrhea ☐ Vomiting ☐ Wheezing
Penicillin	☐ Rash ☐ Nausea ☐ Diarrhea ☐ Vomiting ☐ Wheezing ☐ Other
Iodine	☐ Rash ☐ Nausea ☐ Diarrhea ☐ Vomiting ☐ Wheezing ☐ Other
Sulfa	☐ Rash ☐ Nausea ☐ Diarrhea ☐ Vomiting ☐ Wheezing ☐ Other
Codeine	☐ Rash ☐ Nausea ☐ Diarrhea ☐ Vomiting ☐ Wheezing ☐ Other

Latex/Rubber/Tape: ☐ Rash ☐ Other

Food Allergies/Reactions:

_____

_____

_____

Other drug allergies/reaction: _____

Surgical History:

Please list any surgeries, hospitalizations, trauma you have had. What year? Which hospital?

_____

_____

_____

Social History:

Occupation_____ Hours/week: _____ Satisfied with job: _____

Work Status: ☐ Retired (Year Retired? _____) ☐ On Leave

Alcohol _____drinks per week Coffee / Tea _____cups/day

Tobacco: Smoking _____cigarettes/day ___# Years: _____ Year quit:_____

Chewing _____cans/week _____# Years: _____ Year quit:_____

Recreational drugs _____ Last used:_____

Do you follow a particular diet? (explain) _____

Do you exercise regularly? _____

Family History: (If any relative has suffered any of the following, mark and indicate which relative)

F – Father M – Mother S – Sibling C – Child R – Other Relative

Arthritis / Gout	F M S C R	Gastritis	F M S C R	Liver disease / hepatitis	F M S C R
Asthma	F M S C R	Heart Disease	F M S C R	Rheumatoid Disease	F M S C R
Bleeding Tendency	F M S C R	Hereditary defects	F M S C R	Liver disease / hepatitis	F M S C R
Cancer	F M S C R	HIV / AIDS	F M S C R	Seizures	F M S C R
Diabetes	F M S C R	Hypertension	F M S C R	Stroke	F M S C R

Methodist
BRAIN AND SPINE INSTITUTE

Patient's Name _____

Date of Birth _____

Systems Review: Check any of the following which you have had in the last 3 months

General	Gastrointestinal	Musculoskeletal
☐ Fatigue	☐ Abdominal pain (chronic)	☐ Aching Joints
☐ Fever or chills	☐ Bloody or tarry stools	☐ Back pain
	☐ Change in bowel habits	☐ Bone fracture
Nutritional	☐ Colitis	☐ Cold / numb feet
☐ Weight loss	☐ Constipation	☐ Cramps
	☐ Diarrhea	☐ Foot pain
Skin	☐ Difficulty swallowing	☐ Gout
☐ New moles	☐ Diverticulosis	☐ Joint injury
☐ Psoriasis / Eczema	☐ Gallbladder trouble	☐ Joint pain
☐ Rash / hives	☐ Heartburn	☐ Loss of control of arms or legs
	☐ Hemorrhoids	☐ Loss of Muscle Bulk
Eyes	☐ Hepatitis	☐ Masses in limbs
☐ Eye infections	☐ Hernia	☐ Neck Pain
☐ Eye Irritation and itching	☐ Jaundice	☐ Neck Spasm
☐ Eye pain	☐ Loss of appetite	☐ Swelling of limbs
☐ Vision change	☐ Nausea / vomiting	☐ Weakness
Ears	**Cardiac**	**Neurologic**
☐ Dizziness	☐ Chest pain	☐ Dizziness
☐ Ear infections (frequent)	☐ Heart murmur	☐ Headache
☐ Ear pain	☐ Irregular pulse	☐ Muscle weakness
☐ Hearing loss	☐ Leg pain when walking	☐ Numbness or tingling
☐ Popping - pressure	☐ Phlebitis	☐ Passing out
☐ Ringing in ears	☐ Swollen ankles	☐ Seizures
	☐ Varicose Veins	☐ Tremor
Respiratory		
☐ Asthma / wheezing	**Urinary**	**Endocrine**
☐ Bronchitis	☐ Blood in urine	☐ Frequent urination
☐ Cough	☐ Decreased force or flow	☐ Heat or cold intolerance
☐ Pneumonia	☐ Frequent urination	☐ Thirst
☐ Shortness of breath	☐ Kidney stones	
	☐ Loss of urinary control	**Psychiatric**
Hematology	☐ Painful urination	☐ Depression
☐ Bleeding	☐ Urination >2x nightly	☐ Memory loss
☐ Blood transfusions (lifetime)	☐ Urine infections	☐ Mental illness
☐ Bruising		☐ Moodiness
☐ Enlarged lymph nodes	**Genital**	☐ Nervousness
	☐ Discharge	☐ Phobias
Allergies / Immune	☐ Irritation / Infection	☐ Sleeping difficulty
☐ Frequent illnesses	☐ Sexual difficulties	
☐ Seasonal allergies		

Methodist
BRAIN AND SPINE INSTITUTE

Patient's Name _____

Date of Birth _____

Where is your pain now?

Mark the areas on your body where you feel the described sensations. Please use the appropriate symbol(s) to show the type of pain and include all affected areas.

Numbness	Pins and Needles	Burning	Stabbing	Ache
II II II II	0 0 0 0 0	x x x x x	//////	^ ^ ^ ^