

Osama Ahmed, MD

Toinette Garza, NP-C / Kimberly Ramos, NP-C

 12709 Toepperwein Rd, Suite 101, Live Oak, TX 78233 • W: 210-625-4733 • F: 210-625-4734 • www.bsiofsa.com

**PATIENT INFORMATION :**

□ Dr. □Miss □Mr. □Mrs. □Ms. □Sir

 Patients Name (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Ml) \_\_\_\_ Previous Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext. \_\_\_\_\_\_\_\_\_\_

Primary Care Provider (PCP) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rendering Provider Name (this practice) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: MM\_\_\_\_\_\_\_\_/DD\_\_\_\_\_\_\_\_/YYYY\_\_\_\_\_\_\_\_\_\_ Sex: □Female □Male □Transgender

Race: □ American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: □Married □Single □Divorced □Widowed □Legally Separated □ Partner

Social Security Number: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: □Full-time □Part-time □Not employed □Self-employed □Retired □Active Military

Student Status: □Full-time student □Part-time student □Not a student

Emergency Contact Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have a living will? □Yes □No

Emergency Contact Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Guardian

Address Line 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION:**

Responsible Party: □ Another Patient □ Guarantor □ Self Check here if information is same as patient □

Responsible Party Name (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MI) \_\_\_\_\_\_\_

Guarantor Account Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: MM\_\_\_\_\_\_\_\_/DD\_\_\_\_\_\_\_\_/YYYY\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: □ Female □ Male

Address Line 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID (policy Number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copay Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Termination Date \_\_\_\_\_\_\_\_\_\_\_ Date of Birth MM\_\_\_\_\_\_\_\_/DD\_\_\_\_\_\_\_\_/YYYY\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID (policy Number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copay Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Termination Date \_\_\_\_\_\_\_\_\_\_\_ Date of Birth MM\_\_\_\_\_\_\_\_/DD\_\_\_\_\_\_\_\_/YYYY\_\_\_\_\_\_\_\_\_\_

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

**Patient (or Responsible Party) Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



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At Brain and Spine Institute of San Antonio, our providers strive to provide the most up-to-date neurosurgical treatment options with the utmost care. To provide the best experience, we ask every patient to review the policies below. Please initial indicating your understanding below:

Patients new to the office will be asked to arrive 30 minutes prior to their scheduled appointment. The first appointment will require more time to obtain proper medical, family, and social history. It is the patient's responsibility to have pertinent records and/or adequate knowledge of their medical condition/s. Failure to provide pertinent information may delay treatment.

\_\_\_\_\_ It is the patient's responsibility to provide current insurance information and proper identification. The patient must provide the co-pay/co-insurance prior to the appointment. Failure to do so may prevent assessment from a provider and/or cause a delay in treatment. Any remaining balance after the insurance company is billed is the patient's responsibility.

\_\_\_\_\_ If multiple issues/conditions need to be discussed, a second appointment may be required at the provider's discretion.

\_\_\_\_\_ If imaging has been performed prior to the office visit, it is the patient's responsibility to bring the imaging files on a CD. If the imaging center offers to mail it to the office, please decline the request, and bring the CD with you. Our office does not have electronic access to all the imaging centers. A lack of imaging can cause a delay in treatment.

\_\_\_\_\_ Results will not be discussed over the phone in lieu of an office appointment. If a phone consultation is requested, a co-pay will be required in advance.

\_\_\_\_\_ For uninsured/self-pay patients, the visit fee for the appointment will be required in advance of seeing a provider.

\_\_\_\_\_ Cell phone usage in the exam room is prohibited. Cell phone usage to record a conversation is prohibited. The provider will not discuss patient care on the phone with anyone other than the patient or approved power of attorney. The provider will not participate in video conferences. Failure to comply by these rules may prevent treatment.

\_\_\_\_\_ Cancellations or appointment time changes must occur 24 hours prior to the scheduled appointment in order not to be considered a "No Show". It is the patient's responsibility to notify the practice within the specified time. If a patient has three (3) violations, the practice reserves the right to terminate the patient from the practice.

\_\_\_\_\_ Our providers do not dispense narcotics for chronic pain. If pain control is required, our providers can send a referral to a pain management physician.

\_\_\_\_\_ For non-elective surgical patients: Pain medication will be administered by the patient hospitalist for the post-operative period. If prolonged pain control is needed after surgery, establishing care with a pain management physician will be required.

\_\_\_\_\_ For elective surgical patients: Pre-operative instructions as well as prescriptions will be provided in the office prior to your scheduled surgery.

\_\_\_\_\_ Our practice does not provide refill for medications. Any prescriptions given will provide adequate coverage between appointments. If an exception must be made, the patient will need to come to the office for a consultation.

\_\_\_\_\_ Disability, short-term and long-term leave paperwork is reserved for patients treated with surgery by Dr. Ahmed. Any paperwork completed by our providers will require a pre-payment of $25 and can take 7-10 business days to complete. Please do not expect paperwork to be completed on short notice.

\_\_\_\_\_ If there is a medical emergency at any time, please call 911. If medical attention is needed during regular business hours, please call the office and every effort will be made to schedule a prompt appointment.

\_\_\_\_\_ If medical attention is needed due to pain after regular business hours, please go to the nearest urgent care center.

\_\_\_\_\_ Our providers will not call in prescriptions after hours. Pain medication is reserved for patients who have been treated with surgery. Lon-term pain control will require referral to a pain management physician.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

 (Printed patient name) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

(Witness or medical power of attorney) (Date)

PATIENT HIP AA ACKNOWLEDGMENT AND CONSENT FORM

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Last Name (Printed) | Patient First Name (Printed) | MI | Date of Birth (MM/DD/YYYY) |
|  |  |  |  |

##  Notice of Privacy Practice/clinics

 (Patient/Representative initials) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for Its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

## Disclosures to Friends and/or Family Members

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship |  | Contact Number |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?** I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing

## Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

## Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinics health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

## Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

**Note:** This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

PATIENT HIP AA ACKNOWLEDGMENT AND CONSENT FORM

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Last Name (Printed) | Patient First Name (Printed) | MI | Date of Birth (MM/DD/YYYY) |
|  |  |  |  |

## Release of Information

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

* Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient’s behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer’s designee when the services delivered are related to a claim under worker’s compensation.
* If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse’s notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
* Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to; improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

|  |  |  |
| --- | --- | --- |
| Patient/Representative Signature | Relationship to Patient (self, parent, legal, guardian/representative, etc.) | Date |
|  |  |  |



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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Consent for Financial Communications

**Financial Agreement**

* I acknowledge, that as a courtesy, BRAIN AND SPINE INSTITUTE OF SAN ANTONIO may bill my insurance company for services provided to me.
* I agree to pay for services that are not covered, or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
* I understand there is a fee for returned checks.

**Third Party Collection.** I acknowledge BRAIN AND SPINE INSTITUTE OF SAN ANTONIO may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

**Assignment of Benefits.** I hereby assign to BRAIN AND SPINE INSTITUTE OF SAN ANTONIO any insurance or other third-party benefits available for health care services provided to me. I understand BRAIN AND SPINE INSTITUTE OF SAN ANTONIO has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to BRAIN AND SPINE INSTITUTE OF SAN ANTONIO, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

**Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to BRAIN AND SPINE INSTITUTE OF SAN ANTONIO by the Medicare or Medicaid program.

**Consent to Telephone Calls for Financial Communications.** I agree that, in order for BRAIN AND SPINE INSTITUTE OF SAN ANTONIO, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that BRAIN AND SPINE INSTITUTE OF SAN ANTONIO or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or BRAIN AND SPINE INSTITUTE OF SAN ANTONIO or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

**Patient/patient representative signature :** **Date :**

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse Guarantor

Parent Healthcare Power of Attorney

Legal Guardian Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**New Patient Health History**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ HT: \_\_\_\_\_\_\_\_\_ WT: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Diagnosis: (Please circle all that apply)

\_\_\_ Asthma

\_\_\_ Gastrointestinal

\_\_\_ Bladder Problems

\_\_\_ Jaundice

\_\_\_ Psychiatric Disorder

\_\_\_ Tuberculosis

\_\_\_ Liver

\_\_\_ Diabetes

\_\_\_ Prostate

\_\_\_ Skin Disease

\_\_\_ Joint Disease

\_\_\_ Stroke

\_\_\_ Blood Clots

\_\_\_ Lung Cancer

\_\_\_ Epilepsy

\_\_\_ High Blood Pressure

\_\_\_ Heart Disease

\_\_\_ Seizures

\_\_\_ Depression

\_\_\_ Anxiety

\_\_\_ Gout

\_\_\_ Alcoholism

\_\_\_ Kidney Disease

\_\_\_ Thyroid

##

## Any Surgical History: (Month/Year)

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

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

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

Family History: (Check if any blood relative has had any of the following)

Indicate which immediate relative **Mother/Father/Brother/Sister ONLY**

**\_\_\_ Diabetes**

**\_\_\_ Heart Disease**

**\_\_\_ Migraines**

**\_\_\_ Alcoholism**

**\_\_\_ Cancer**

**\_\_\_ Arthritis**

**\_\_\_ Osteoporosis**

**\_\_\_ Anemia**

**\_\_\_ Thyroid Problem**

**\_\_\_ High Blood Pressure**

**\_\_\_ Mental Illness**

**\_\_\_ High Cholesterol**

**\_\_\_ Glaucoma**

**\_\_\_ Stroke**

**\_\_\_ Seizures**

**\_\_\_ Allergies**

**\_\_\_ Meniere’s Disease**

**\_\_\_ Asthma**

**\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Social History:

Do you currently smoke or have previously? Y/N If so, how many cigarettes per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Y/ N How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use illegal drugs? Y/ N If so, what do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink caffeine? Y / N If so, how many cups/cans per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If None, circle: Retired / Disabled / Unemployed

Last dates of the following screening(s): A1C: \_\_\_/\_\_\_/\_\_\_ Mammogram: \_\_\_/\_\_\_/\_\_\_Colonoscopy: \_\_\_/\_\_\_/\_\_\_

Last flu vaccine? Date: \_\_\_/\_\_\_/\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last pneumovax (pneumonia) vaccine: Date: \_\_\_/\_\_\_/\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BACK OFFICE NOTES:



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

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Constitutional**

 Sweats

 Weight gain

 Weight loss

 Fever

 Fatigue

 Sleep difficulty

 **Psychiatric**

Claustrophobia

 Depression

 Nervousness

 Hallucinations

 Paranoia

 **Ear, Nose, & Throat**

 Hearing loss

 Ringing in the ears

 Sinus congestion

 Nose bleeds

 Sore throat

 Swallowing difficulty

 Loose teeth

 **Respiratory**

 Chronic cough

 Sleep apnea

 Shortness of breath

 Asthma

Wheezing

 Sputum production

 **Cardiovascular**

 Chest pain

 Irregular heartbeat

 Swelling in legs/feet

 **Gastrointestinal**

 Heartburn

 Constipation

 Diarrhea

 Nausea

Blood in stool

Incontinence

**Genitourinary**

Incontinence

Painful urination

Urinary frequency

Urgency

Prostate problems

Impotence

**Musculoskeletal**

Joint pain

Aches

Shoulder pain

Back pain

Neck pain

Muscle spasms

**Hematological**

Anemia

Bruising

Clotting disorders

**Neurological**

Dizziness

Loss of Consciousness

Tremor

Word finding difficulty

Stroke

Meningitis

Facial Weakness

Seizures

Spasms

Balance difficulty

Memory loss

Headaches

Double vision

Blurry vision

Vision loss

Numbness/tingling (if so,

where)

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



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 **Medication Log**

**Patient Full Name:** **DOB:**

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| **Medication Allergies & Reactions:** |  |  |
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| **CURRENT MEDICATION REGIMEN** |  |  |
| MEDICATION NAME | DOSE/SIG/MG | PrescribingPhysician | REASON TAKEN |
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| ADDITIONAL INFORMATION: |  |  |
| PHARMACY: |  | PHARMACY PHONENUMBER: |