VALLEY NEURO/MICRONEUROSURGERY, S.C.
K.S. PAUL, M.D.

PATIENT INFORMATION FORM

Patient Name: _____ Age: _____
Last First Middle Initial

Former Names: _____ (if applicable) Sex: ☐M ☐F

Date of Birth: _____ Social Security #: _____

Mailing Address: _____
City State Zip code

Phone: (_____)_____(_____)_____(_____)_____
Home Work Cell

Employer: _____
Name

_____
Address City State Zip code

Emergency Contact: _____Phone:_____

Spouse (if minor: Parent/Guardian):_____

Spouse's Employer: _____

Family Physician: _____ Phone: (_____) _____

Address: _____
City State Zip Code

Referring Physician: _____ Phone: (_____) _____

Address: _____
City State Zip Code

Insurance Company

Name: _____

Policy Holder Name: _____ Date of Birth: _____

Relation to Patient: _____

Secondary Insurance Company

Name: _____

Policy Holder Name: _____ Date of Birth: _____

Relation to Patient: _____

Are you currently working? _____ Date last worked: _____

Is this a work-related injury? _____Date of Injury?_____

File with Workman's Compensation first? _____ YES _____ NO

Workman's Compensation

W/C Insurance: _____ Claim #: _____

Address: _____ Phone #: (_____) _____

_____ Contact Name: _____

City State Zip Code

Employer: _____ Phone #: (_____) _____

Address: _____

City State Zip Code

Is this related to an auto accident? _____ Date of Accident: _____

Is this a personal injury? _____ Date of Accident: _____

File with Auto/Personal Injury first? _____ YES _____ NO

Accident/Personal Injury Insurance

**Have you filed a claim with your auto accident/personal injury insurance? ** _____

Insurance Company Name: _____ Phone # :(_____) _____

Address: _____

City State Zip Code

Claim or Policy #: _____ Insured Party's Name: _____

Attorney

Is there a lawsuit pending? _____

Attorney's Name: _____Phone #: (_____) _____

Address: _____

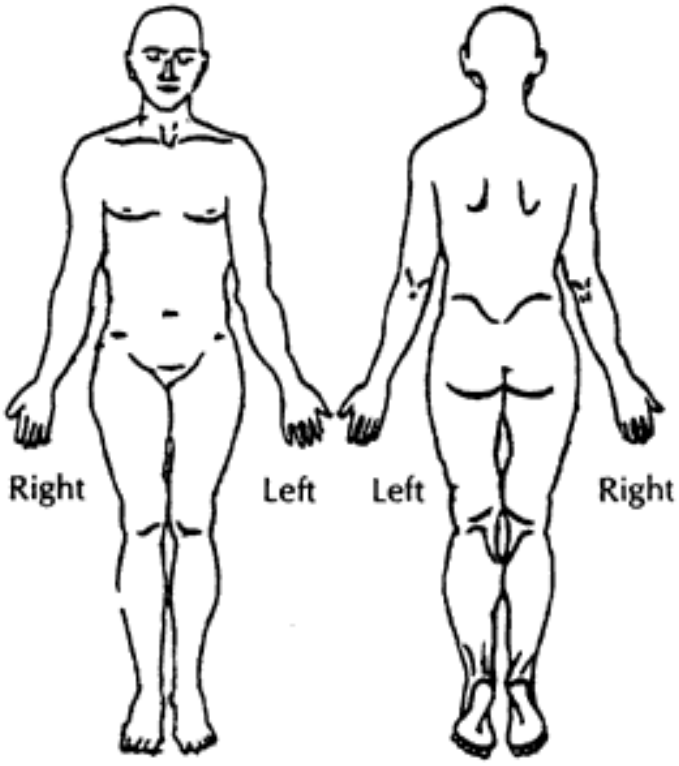
City State Zip Code

*I hereby authorize the release of my medical information to the insurance carrier, employer, referring and/or family physician, necessary to process my claim and/or provide medical care.
Signature: _____ Date: _____

*I hereby authorize direct payment to Valley Neuro/Microneurosurgery, S.C. (K.S. Paul, M.D.) of all insurance benefits, all Medicare benefits, and all Medigap insurance benefits (as applicable) otherwise payable to me. I understand that I am financially responsible for charge(s) which are not paid and/or not covered by my insurance plan(s). This authorization is in effect until I choose to revoke it and it can be revoked at any time.
Signature: _____ Date: _____

Pain Diagram

Please tell us where your pain is located by manually drawing X's on the diagram after printing completed forms



NECK

Pain rating when pain is at its best: _____

Pain rating when pain is at its worst: _____

Is the pain: ____Aching? ____Stabbing? ____ Burning? ____Pins & Needles? ____Complete Numbness?

ARM

Pain rating when pain is at its best: _____

Pain rating when pain is at its worst: _____

Is the pain: ____Aching? ____Stabbing? ____ Burning? ____Pins & Needles? ____Complete Numbness?

BACK

Pain rating when pain is at its best: _____

Pain rating when pain is at its worst: _____

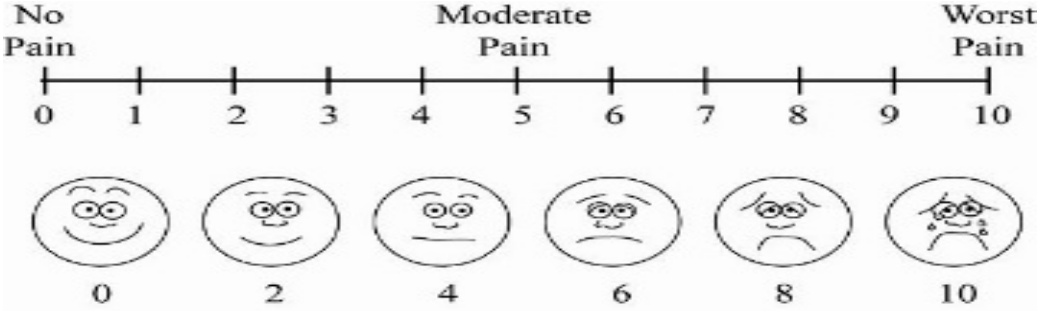
Is the pain: ____Aching? ____Stabbing? ____ Burning? ____Pins & Needles? ____Complete Numbness?

LEG

Pain rating when pain is at its best: _____

Pain rating when pain is at its worst: _____

Is the pain: ____Aching? ____Stabbing? ____ Burning? ____Pins & Needles? ____Complete Numbness?



MEDICAL HISTORY

Past Medical History *(Please check all that apply)*

	High Blood Pressure		Asthma		Blood Clots
	Diabetes		Tuberculosis		Depression
	Cancer		Emphysema		Anxiety Disorder
	Seizures		Angina		Bipolar disorder
	Rheumatoid Arthritis		Heart Attack		Other Mental Illness
	Gout		Irregular Heart Beat		Addiction to Alcohol
	Thyroid Disease		Abnormal Heart Valve		Addiction to Other Drugs
	Osteoporosis		Aortic Aneurysm		HIV / AIDS
	Glaucoma		Poor Circulation		Hepatitis
	Migraine Headaches		Ulcers in Stomach or Intestines		Broken Bones
	Loss of Consciousness		Kidney Problems		Prolonged Prednisone Use
	Stroke or TIA		Liver Problems		Sleep Apnea
	Severe Head Injury		Bowel Problems		Major Trauma (accidents, falls)
	Brain Aneurysm		Easy Bleeding		Other: _____

Past Surgical and/or Hospitalization History
(Please check the operations you have had/indicate hospitalization and for what reason)

	Tonsillectomy		Appendectomy		Gallbladder
	Hysterectomy		Neck Operation		Heart Surgery
	Bypass in the legs		Back Operation		Brain Surgery
	Bowel Surgery		Gastric Bypass		Other: _____
	Carotid Endarterectomy		Tubal Ligation		Other: _____
	Abdominal Aneurysm		Cesarean Section		Other: _____

Are you currently (or in the last 6 months) having any of the following symptoms?

CONSTITUTIONAL

___ Weight Change
___ Sleep pattern change
___ Appetite change
___ Fevers
___ Chills
___ Fatigue

CARDIOVASCULAR

___ Chest pain
___ Palpitations
___ Swollen Ankles
___ Other: _____
___ Other: _____

PULMONARY

___ Shortness of breath
___ Cough
___ Wheezing
___ Heavy Snoring
___ Other: _____

GASTROINTESTINAL

___ Heartburn
___ Constipation
___ Diarrhea
___ Change in bowel habits
___ Loss of bowel control
___ Trouble swallowing
___ Other: _____

GENITO-URINARY

___ Painful urination
___ Frequent urination
___ Incontinence
___ Other: _____
___ Other: _____

MUSCULO/SKELETAL

___ Joint pain/swelling
___ Muscle pain/cramps
___ Low back pain
___ Neck pain
___ Leg pain
___ Arm pain

PSYCHIATRIC

___ Depression
___ Anxiety
___ Other: _____
___ Other: _____

IMMUNOLOGICAL

___ HIV / AIDS
___ Blood Cancers
___ Other: _____
___ Other: _____

ENDOCRINOLOGY

___ Thyroid disease
___ High blood sugar
___ Other: _____
___ Other: _____

INTEGUMENTARY

___ Rashes
___ Other: _____
___ Other: _____

NEUROLOGICAL

___ Loss of balance
___ Headache
___ Weakness
___ Vision change
___ Hearing problems
___ Dizziness/fainting
___ Clumsiness
___ Speech problems
___ Numbness/tingling
___ Arms ____ Hands
____ Legs ____ Feet

HEMATOLOGIC

___ Bleeding disorder
___ Easy bleeding
___ Easy bruising
___ Other: _____

FAMILY HISTORY *(Please check all that apply)*

Disease/Condition	Mother	Father	Grandparents	Siblings	Children
Heart Disease					
High Blood Pressure					
Diabetes					
Cancer (what type of cancer?)					
Arthritis					
Bleeding Disorder					
Kidney Disorder					
Thyroid Disease					
Nervous System Tumors					
Epilepsy					
Stroke					
Mental Illness					
Dementia					
Parkinson's Disease					
Tremor					
Multiple Sclerosis					
Muscular Dystrophy					
Migraine Headaches					
Cerebral Palsy					
Reaction to Anesthesia					
Other: _____					
Other: _____					

SOCIAL HISTORY/HABITS

Marital Status (circle one): Single ☐ Married ☐ Divorced ☐ Widowed ☐
Separated ☐ Domestic Partnership ☐ Other: _____

Children: Number of Children: _____ Ages of Children: _____

Smoking

_____ Never Smoked
_____ Former Smoker
_____ Currently Smoke

How many packs a day did you smoke before? _____
How many years ago did you smoke? _____
What year did you stop smoking? _____
How many packs per day do you smoke? _____
How many years have you smoked? _____

Alcohol Use

Do you drink alcohol? *(Check One)* _____Never _____Occasional Social Drink
_____ 1-3 drinks per day _____ 4+ drinks per day

If you drink alcohol, do you drink to relieve pain? _____ Yes _____ No

Do you drink caffeinated beverages? (Coffee, soda) _____ Yes _____ No

Do you use street drugs? _____ Yes _____ No

****Most health insurance companies require that you receive conservative treatment before they will authorize additional testing and/or surgery. It is important that you complete this form. ****

Conservative Treatment (In the last 6 months)

Pain Relief Effect: No Relief / Some Relief / Temporary Relief / Full Relief

Anti-Inflammatory Medications

Medication Name	Date Started/Stopped	Pain Relief Effect
	/	
	/	
	/	

Pain Medications

Medication Name	Date Started/Stopped	Pain Relief Effect
	/	
	/	
	/	
	/	

Daily Exercise

Type of Exercise	Duration	Pain Relief Effect

Activity / Lifestyle Modification

Modification Type	Date Started	Pain Relief Effect

Weight Reduction

Reduction Type (diet, exercise, surgical procedure)	Date Started	Pain Relief Effect

Supervised Physical Therapy

Where was PT done?	Date Started/Stopped	Pain Relief Effect
	/	
	/	

Cognitive / Behavioral / Addiction Issues

Identified Issue	Treatment Received

Chiropractic Care

Where was chiropractic care done?	Date Started/Stopped	Pain Relief Effect
	/	
	/	

Other

(TENs Unit, Acupuncture, Hypnosis, Injections, etc.)

Type of Treatment	Date Started/Stopped	Pain Relief Effect
	/	
	/	
	/	

Do you have any reaction to anesthesia? _____

Are you allergic to LATEX? _____

_____ I do not have any known allergies.

Allergy	**When did you develop this allergy?**	**Reaction**	**Location of Body**	**Severity**
i.e.: type of medication, food, or environmental allergy	*i.e.: as a child, adult, unknown*	*i.e.: rash, hives, swelling, nausea*		*Mild, moderate, or severe*

Medications List

** IMPORTANT: Due to electronic medical records, medication lists **must** be clearly written and have *accurate spelling* of all medications. **

Pharmacy Name (that you currently use): _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

___ ___ I currently do not take any medications (including over the counter, herbs, vitamins, and illegal/street drugs)

MEDICATIONS (Include prescriptions, over the counter, herbs, vitamins, and illegal/street drugs)

Medication Name (spelled accurately)	Dosage	Frequency	Medication Start Date	Prescribing M.D.
Example: Bayer aspirin	*325 mg*	*1 tablet daily*	*8/1/2011*	*Over the Counter*

NONCURRENT MEDICATIONS

Medications Prescribed/Tried	Taken For This Problem	Date Stopped Taking

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K.S. PAUL M.D.

MEDICAL RECORDS

Important notice regarding your medical records: Your medical records with Dr. Paul, Valley Neuro/Microneurosurgery, S.C. are maintained for **10 (ten) years** after you are discharged from our care, at which time they are destroyed. You may obtain a copy of your medical records upon discharge or any time within the 10 (ten) years after discharge.

ACCESS TO MY MEDICAL RECORDS:

I have received information regarding setting up my Patient Fusion account and:

___ ___ I am choosing to opt-out from having direct access to my medical records via email

___ ___ I would like to have direct access to my medical records via email.

My email address is: _____

_____ I would like to receive appointment remainders via email.

_____ I would like to receive text message reminders via my cell phone.

RELEASE OF INFORMATION

*By initialing here, _____, I authorize you to leave a voice mail message regarding appointment reminders or a need to return a phone call to your office.
*By initialing here, _____, I authorize you to leave a message with anyone answering my home phone regarding appointment reminders or a need to return a phone call to your office.
*By initialing here, _____, I authorize you to leave a message at my work that I need to return a phone call to your office.

*I authorize you to discuss my medical records with (family member, friend, neighbor, etc.):
_____ Relation: _____
_____ Relation: _____
_____ Relation: _____
This authorization includes my medical condition, treatment, appointments, and billing information. I understand that this authorization will remain in effect unless revoked by me in writing.

Signature: _____ Date: _____

VACCINATION STATUS (Month and year vaccination was receive)
Pneumovax _____ Influenza _____ Tetanus _____

CODE STATUS

If a major medical event were to occur, would you want:
_____ Full Code (Which means you would want all medical means used)
_____ No Code (Do Not Resuscitate)
_____ I have an Advance Directive for Health Care (Living will or power of attorney for health care)

_____ I do not have an Advance Directive for Health Care and would like more information about it.

Information provided to patient _____

Valley Neuro/Microneurosurgery, S.C.

PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

We would like to thank you for choosing us as your healthcare provider. We are committed to providing you the best service possible. As one of our patients, we would like to keep you informed of our office and financial policies. Please feel free to call us if you have any questions regarding these policies.

Insurance Claims: As a courtesy to you, we file insurance claims with your insurance carrier for you. It is your responsibility to provide us with your insurance information. Please be sure to bring your current insurance cards with you to your appointment. We will need this insurance information even if your inquiry is due to a work, auto, or personal injury. We accept Medicare, Medicare Assignment, and Medical Assistance, as well as private insurance. Please be sure to confirm with your insurance company as to your covered benefits, in-plan providers, and your co-pay and co-insurance responsibilities.

Patient Financial Responsibility: Your insurance may dictate that we collect co-payments, deductibles, and co-insurance, which is not subject to discounts and adjustments. Appropriate adjustments will be made to your account should we hold a contract with your insurance company. You may also be responsible for 1) denied claims, 2) partial payment such as the health plan's arbitrary determination of "usual and customary" rates, and 3) non-covered services.

Co-payments: Payment is due at the time of service at every appointment. We accept cash or check, as well as major credit cards/debit cards. These include: Visa, MasterCard, American Express, and Discover. **NOTE: Any payment made with a credit or debit card will be subject to a service fee charge.**

Workman's Compensation & Auto or Personal Injury Claims: You will need to provide us the proper filing information for your claim (correct address and claim number) *at the time of your appointment.*

Self-Pay Agreements: Our office does accept self-pay patients. At the time of each visit you will need to provide a $25 payment, which is deducted from your final bill. In addition, a monthly payment plan will be established, with the monthly payment amount established at the first appointment.

Referrals: Many insurance companies will not pay for services rendered by a specialist without a referral. It is the responsibility of the patient to obtain any referral that is required by the health insurance plan.

Delinquent Accounts: All accounts must be satisfied within **90 days** unless arrangements have been made with our Billing Department. A prior arrangement for a regular scheduled payment plan is required. If you have a financial hardship, a copy of your most recent tax return is required. We may reschedule appointments or discontinue our relationship with you should bills go unpaid and no attempt has been made to reconcile the account.

Overdue Accounts: Overdue accounts for collection may be subject to a monthly 1.5% late fee charge, added to the overdue balance. If the account is sent to our collection agency, 34% of the balance due will also be added to the account balance due.

NSF Fee: There is a $35.00 service charge for any returned check.

I have read, understand, and agree to this financial policy. Also, I am aware that I am responsible for all charges incurred. I further agree that any and all monies paid directly to me by my insurance carrier or as a settlement for a workman's compensation, personal, or auto accident claim are owed to Valley Neuro/Microneurosurgery, S.C. up to the amount of payment in full of medical expenses I incurred and promise that I will pay Valley Neuro/Microneurosurgery, S.C. those monies due that I have been paid directly by my insurance company, workman's compensation, personal, or auto accident claim. I am also liable for all legal expenses incurred by Valley Neuro/Microneurosurgery, S.C. that may occur in collecting monies due Valley Neuro/Microneurosurgery, S.C. by me for medical treatment I have received.

_____ _____

Patient or Responsible Party *Date*

Financial Policy Revised 10/2013