

Advanced
Neurosurgery
REGISTRATION FORM
(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Email address:	(Former name):			Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:		Home phone no.: ()		
Cell phone no.: ()	City:		State:		ZIP Code:		
Occupation:	Employer:			Employer phone no.: ()			
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
In case of emergency:	Name:	Home phone no.:	Work phone no.:	Relation to patient:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ()
Relation to Patient:			Social Security no.:	
Occupation:	Employer:	Employer address:		Employer phone no.: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please indicate primary insurance company:				
Contract no.:		Group no.:	Subscriber no.:	
Name of secondary insurance (if applicable):	Subscriber's name:		Relation to patient:	Birthday: / /
Address (if different from patient's):				
Subscriber employed by:		Business phone no.: ()	Social Security no.:	

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Song all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient/Guardian signature

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Advanced
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HEALTH HISTORY
(Please Print)

Patient Name:		Today's Date: / /
Age:	Birth date: / /	Occupation:

1. Are you Right handed or Left Handed? ___ Right ___ Left

2. What brings you in today? ___ Neck pain ___ Upper back pain ___ Mid back pain ___ Low back pain
___ Shoulder pain ___ Arm pain (Right or Left) ___ Elbow Pain ___ Forearm pain ___ Leg pain (Right or
Left) ___ Thigh pain ___ Calf pain ___ Knee pain ___ Foot pain
___ Other: _____

3. When did it start? _____

4. Has the pain stayed the same, gotten worse, or improved? _____

5. Is the pain: ___ Severe ___ Moderate ___ Mild ___ Slight

6. Is the pain: ___ Constant ___ Occasional

7. Does the pain radiate? ___ If yes, where? _____

8. Is the pain: ___ Burning ___ Sharp ___ Aching ___ Dull ___ Stabbing ___ Other: _____

9. What makes it better? _____

10. What makes it worse? _____

11. Have you tried: ___ Physical Therapy ___ Epidural Steroid Injections ___ Massage ___ Acupuncture
___ Chiropractor ___ Other: _____

12. Are you having any:
 - a. Numbness, if yes where: _____
 - b. Tingling, if yes where: _____
 - c. Weakness, if yes where: _____

13. What medications are you taking specifically for this problem?

14. What tests have you had done for this problem: ___ MRI ___ CT ___ X-rays ___ EMG

CMS: Centers for Medicare & Medicaid Services OBJ-304C Meaningful Use Required Questionnaire:

1. Ethnicity
Please specify your ethnicity.
o Hispanic or Latino
o Not Hispanic or Latino

2. Race
Please specify your race.
o American Indian or Alaska Native
o Asian
o Black or African American
o Native Hawaiian or Other Pacific Islander
o White

3. Language
Please specify your preferred language.
o English
o Spanish
o Indian (Includes Hindi & Tamil)
o Russian
o Other

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HEALTH HISTORY

SYMPTOMS			
Check (√) conditions you currently have or have had in the past year			
GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other
<input type="checkbox"/> Headache	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Ear discharge	
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay fever	WOMEN only
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Numbness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Sweats	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Extreme menstrual pain
	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Hot flashes
MUSCLE/JOINT/BONE	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nipple discharge
Pain, weakness, numbness in:	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Vision – Flashes	<input type="checkbox"/> Painful intercourse
<input type="checkbox"/> Arms <input type="checkbox"/> Hips		<input type="checkbox"/> Vision – Halos	<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Back <input type="checkbox"/> Legs	CARDIOVASCULAR		<input type="checkbox"/> Other
<input type="checkbox"/> Feet <input type="checkbox"/> Neck	<input type="checkbox"/> Chest pain	SKIN	Date of last menstrual period _____
<input type="checkbox"/> Hands <input type="checkbox"/> Shoulder	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bruise easily	Date of last Pap Smear _____
	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Hives	Have you had a mammogram? _____
GENITO-URINARY	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Itching	Are you pregnant? _____
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Change in moles	Number of children _____
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Rash	
<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Scars	
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Sore that won't heal	

CONDITIONS			
Check (√) conditions you currently have or have had in the past year			
<input type="checkbox"/> AIDS	<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Herpes	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease

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HEALTH HISTORY
(Please Print)

MEDICATIONS – List medications you are currently taking.	
Pharmacy Name	Phone

ALLERGIES

FAMILY HISTORY							
Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if, your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Stroke	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS		
Year	Hospital	Reason for Hospitalization and Outcome
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please give approximate dates ____/____/____		
Serious Illness/Injuries	Date	Outcome

PREGNANCIES			HEALTH HABITS			OCCUPATIONAL			
Year of birth	Sex of birth	Complications if any	Check (√) which you use and how much you use.			Check (√) if your work exposes you to:			
				Caffeine			Stress		Hazardous Substances
				Tobacco			Heavy Lifting		Other
				Street Drugs			Occupation:		
				Other					

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Guardian or Personal Representative

Relationship to Patient