Advanced Neurosurgery

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:			☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Email address:		(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ 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):	☐Dr.	☐ Insurance Plan	☐ Hospital			
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ 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? ☐ Yes ☐ 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*

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

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