PATIENT REGISTRATION FORM

**********Patient Information**********

Pt. Last Name	First	Middle Init

SSN	Date of Birth	Age	Gender	Marital Status

Address	City	St	Zip

Home phone	Cell phone	Email	Work phone

Contact Preference for appt reminders, medical information and financial info (Please rank by preference – 1 – 5):
_____ Cell Phone _____ Email _____ Text _____ Home Phone _____ Work Phone

Employer	Emp Address	City	St	Zip	Emp Phone

Pharmacy Name & Location	Phone Number

**********Spouse / Guardian Information**********

Spouse/Guardian Last Name	First	Middle Init

SSN	Date of Birth			

Address (if different from Patient)	City	St	Zip

Home phone	Work phone	Cell phone

Employer	Emp Address	City	St	Zip	Emp Phone

**********Contact in Case of Emergency**********

Contact Name	Relationship

Home Phone	Cell Phone	Work Phone

Do you authorize this office to discuss your care or treatment with any party besides yourself	N	Y

If so, with whom?:

**********Referring Physician**********

Referred by:

If referred by Doctor: Address	City	St	Zip

Phone	Fax

**********Primary Care Physician**********

Primary Care Physician

Address	City	St	Zip

Phone	Fax

Initial _____ Date _____

**********Financial Responsibility**********

Person Financially Responsible for Balance Not Covered by Insurance	Relation (Patient/Parent/Guardian)
Name on Credit Card	

Visa Card # / Master Card # / Discover Card #	Exp Date	CVCODE

I hereby authorize the doctor to charge my listed credit card account any unpaid balance

Signature	Date

**********Primary Insurance Information**********

Insurance Co.	Subscriber	Date of Birth
ID	Group	

Mailing Address	City	St	Zip
Phone			

**********Secondary Insurance Information**********

Insurance Co.	Subscriber	Date of Birth
ID	Group	

Mailing Address	City	St	Zip
Phone			

**********W/C or Accident Insurance Specific Information**********

W/C or Accident Insurance Name	Adjuster's Name		
Address	City	St	Zip
Phone	Fax	Claim #	

Do you have an attorney handling your claim?	Name		
Address	City	St	Zip
Phone	Fax	Claim #	

I authorize the Release of any Medical Information to process my claim and request Payment of Benefits to the Physician. I understand that responsibility for payment for neurosurgical services provided by this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance.

Relationship to patient	**Date**
Signature	

Initial _____ Date _____

**********Health Information**********

Reason for Visit	
Approximate date of condition onset	
Have any tests been done?	What was done?
Has any treatment been tried?	What was done?

**********Current and Complete Medication List **********
(including over-the-counter drugs such as aspirin, vitamins, herbal supplements)

Medication Name	Dose	How Often

*Drug, Food or Substance Allergies (Including any medications or Latex)** **[IF NO ALLERGIES _____]**

Allergy To:	Reaction Type:	Allergy To:	Reaction Type:

**********Past Medical History (Please check if you have ever had any of the following)**********

	Anemia		CVA/TIA (Stroke)		Coronary Artery Disease		Hypertension		Renal disease
	Angina		Colon cancer		Diabetes		Kidney failure		Seizure disorder
	Asthma		Congestive Heart Failure		Hepatitis C		Liver disease		Thyroid disease
	Atrial fibrillation		COPD		HIV/AIDS		Lung cancer		Prostate cancer
	Blood clots								

**********Past Surgical Procedures and Hospitalizations**********

	Anesthesia reaction			Carpal tunnel release	year:		Thyroidectomy	year:
	Angioplasty with stent	year:		Gallbladder removal	year:		Prostate surgery	year:
	CABG	year:		Hip replacement	year:			year:

Reason	Date	Which Hospital

Initial _____ Date _____

Family History (Please check if any of the following conditions exist within your family (NOT yourself)

	DIAGNOSIS:	WHICH FAMILY MEMBER:	AGE ONSET or DEATH:		DIAGNOSIS:	WHICH FAMILY MEMBER:	AGE ONSET or DEATH:
	Blood disease				High blood pressure		
	CAD				Kidney /bladder problems		
	CVA (Stroke)				Sickle cell anemia		
	Diabetes				Anesthesia problems		
	Cancer (type)						

**********Review of Systems (are you currently having problems with any of the following)**********

CONSTITUTIONAL:		Chills		Fatigue		Fever	Weight change (+ or -)
EYES:		Double Vision		Eye pain		Floaters	Visual loss
EARS/NOSE/THROAT:		Hearing loss/ringing		Nose bleeds		Voice change	Trouble swallowing
RESPIRATORY:		Cough		Short of breath		Frequent infections	Wheezing
CARDIOVASCULAR:		Chest pain		Short of breath		Swelling of legs	Palpitations
GASTROINTESTINAL:		Stomach pain		Fecal incontinence		Rectal bleeding	Vomiting
GENITOURINARY:		Cloudy urine		Decreased stream		Foul urine odor	Frequent urination
		Blood in urine		Kidney stones		Urgency	Urinary incontinence
ENDOCRINE:		Infertility		Excessive urination		Weight gain	Weight loss
NEUROLOGICAL:		Weakness		Headache		Memory impairment	Seizures
PSYCHIATRIC:		Sociability		Frequent upset		Difficulty concentrating	Depression
SKIN:		Frequent skin infections		Nail changes		Rash	Change in mole
MUSCULOSKELETAL:		Back pain		Bone/joint symptoms		Muscle soreness	Neck stiffness
HEMATOLOGIC:		Bleeding Problems		Bruise easily		Enlarged glands	Blood clots
IMMUNOLOGICAL:		Asthma		Chemical at work place		Environmental allergies	Food allergies

Initial _____ Date _____

**********Social History**********

PRIMARY LANGUAGE SPOKEN:		**LANGUAGE SPOKEN AT HOME:**	
COUNTRY OF BIRTH:			

HEIGHT:		**WEIGHT:**				**AGE:**	
HAND DOMINANCE:		Right		Left		Ambidextrous	

PLACE OF EMPLOYMENT:	Phone # and Ext.	Occupation	Employment status
Restrictions	Occupational hazards	Additional hazards	

MARITAL STATUS:		Do you have children?	Yes / No
RESIDENCE INCLUDES WHO BESIDES YOU:			
WHO COMPRISES YOUR SUPPORT NETWORK:			

USES TOBACCO:	Current / Former / Never	Type:	How much daily?	Years used:
Have you ever tried to quit?	Year quit?	Longest time tobacco free:	Relapse reason?	
PASSIVE SMOKE EXPOSURE:	Yes / No			

DO YOU DRINK ALCOHOL:	No	Yes	Formerly
Type:	Frequency:	Amount:	Last Drink:

CAFFEINE: No / Yes	Type:	Type:	Amount per day:

CHANGES IN SLEEP PATTERNS?	If so, what changes?

ACTIVITY LEVEL:	Moderate	Sedentary	Vigorous	Health club member: Now / Previously / Never

PERSONAL SAFETY:	Have you fallen and injured yourself in the last 12 months?	Number of falls:

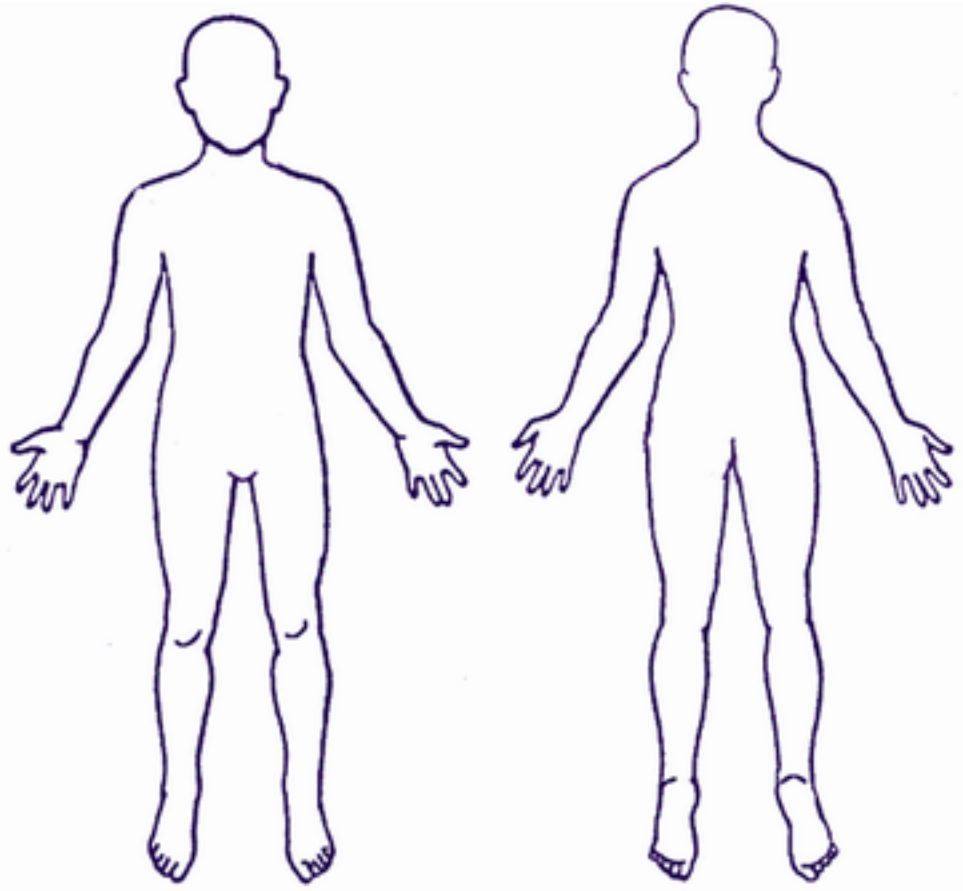
Initial _____ Date _____

Please fill out the pain drawing. This will tell us where your pain is now and something about the pain.

***********Mark the areas on your body where you feel the pain. Use the following patterns:**********

NUMBNESS ----	PINS & NEEDLES o o o o	BURNING x x x x
STABBING / / / /	ACHING + + + +	OTHER * * * *

Right **FRONT** Left Left **BACK** Right



****Visual Analogue Scale Pain Assessment (Please circle the number that best answers the question)****

What is your pain RIGHT NOW?											
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
What is your TYPICAL or AVERAGE pain?											
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?											
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?											
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain

Initial _____ Date _____

CENTER OF BRAIN AND SPINE SURGERY, SC

Modified Oswestry Disability Questionnaire **FORM 1**

Instructions for completing the questionnaire: Please answer every section and circle in each section only the one letter which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just circle the letter which most closely describes your problem.

Patient Name _____

SS #: _____----------_____ Date: _____

Section 1 – Pain Intensity:

A: I can tolerate the pain I have without having to use medication.
B: The pain is bad but I can manage without taking medication.
C: Pain medication provides me with complete relief from pain.
D: Pain medication provides me with moderate relief from pain.
E: Pain medication provides me with little relief from pain.
F: Pain medications have no effect on the pain.

Section 2 – Personal (Washing, Dressing, etc.):

A: I can take care of myself normally without causing increased pain.
B: I can take care of myself normally but it increases my pain.
C: It is painful to take care of myself & I am slow and careful.
D: I need help, but I am able to manage most of my personal care.
E: I need help everyday in most aspects of self care.
F: I do not get dressed, wash with difficulty & stay in bed.

Section 3 – Lifting:

A: I can lift heavy weights without increased pain.
B: I can lift heavy weights but it causes increased pain.
C: Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned. (e.g. on the table).
D: Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E: I can only lift very light weights.
F: I cannot lift or carry anything at all.

Section 4 – Walking:

A: Pain does not prevent me from walking any distance.
B: Pain prevents me walking more than 1 mile.
C: Pain prevents me walking more than ½ mile.
D: Pain prevents me walking more than ¼ mile.
E: I can only walk with crutches or a cane.
F: I am in bed most of the time & have to crawl to the toilet.

Section 5 – Sitting:

A: I can sit in any chair as long as I like.
B: I can only sit in my favorite chair for as long as I like.
C: Pain prevents me sitting more than 1 hour.
D: Pain prevents me from sitting more than ½ hour.
E: Pain prevents me from sitting more than 10 minutes.
F: Pain prevents me from sitting at all.

Section 6 – Standing:

A: I can stand as long as I want without increased pain.
B: I can stand as long as I want, but it increases my pain.
C: Pain prevents me from standing for more than 1 hour.
D: Pain prevents me from standing for more than 30 minutes.
E: Pain prevents me from standing for more than 10 minutes.
F: Pain prevents me from standing at all.

Section 7 – Sleeping:

A: Pain does not prevent me from sleeping well.
B: I can sleep well by using pain medication.
C: Even when I take pain medication, I sleep less than 6 hours.
D: Even when I take pain medication, I sleep less than 4 hours.
E: Even when I take pain medication, I sleep les than 2 hours.
F: Pain prevents me from sleeping at all.

Section 8 – Employment/Homemaking:

A: My normal homemaking/job activities do not cause pain.
B: My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
C: I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming).
D: Pain prevents me from doing anything but light duties.
E: Pain prevents me from doing even light duties.
F: Pain prevents me from performing any job or homemaking chores.

Section 9 – Social Life:

A: My social life is normal and does not increase my pain.
B: My social life is normal, but it increases my level of pain.
C: Pain has no significant effect on my social life apart from limiting my more energetic activities (e.g. dancing, etc).
D: Pain has restricted my social life and I do not go out very often.
E: Pain has restricted my social life to my home.
F: I have no social life because of pain.

Section 10 – Traveling:

A: I can travel anywhere without increased pain.
B: I can travel anywhere, but it increases my pain.
C: Pain is bad but I manage journeys over 2 hours.
D: Pain is bad but I manage journeys less than 1 hour.
E: Pain is bad but I manage journeys less than 1 hour ½ hour.
F: My pin prevents me all travel except for visit to the doctor or hospital.

Section 11 – Pain Level:

On a scale from 1 to 10, circle your level of BACK pain discomfort, with 0 bei

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

On a scale from 0 to 10, circle your level of LEG pain discomfort, with 0 being none and 10 being unbearable.

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Score _____

Initial _____ Date _____

CENTER OF BRAIN AND SPINE SURGERY, SC

Modified Neck Disability Index **FORM**

Instructions for completing the questionnaire: Please answer every section and circle in each section only the one letter which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just circle the letter which most closely describes your problem.

Patient Name _____

SS #: _____----------_____ Date: _____

Section 1 – Pain Intensity:

A: I have no pain at the moment.
B: The pain is mild at the moment.
C: The pain is moderate at the moment.
D: The pain is fairly severe.
E: The pain is very severe.
F: The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.):

A: I can look after myself without causing extra pain.
B: I can look after myself normally but it casues extra pain.
C: It is painful to look after myself and I am slow and careful.
D: I need some help, but manage most of my personal care.
E: I need help everyday in most aspects of self-care.
F: I do not get dressed; I wash with difficulty & stay in bed.

Section 3 – Lifting:

A: I can lift heavy weights without extra pain.
B: I can lift heavy weights, but it causes extra pain.
C: Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D: Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E: I can lift very light weights.
F: I cannot lift or carry anything at all.

Section 4 – Reading:

A: I can read as much as I want to with no pain in my neck.
B: I can read as much as I want with slight pain in my neck.
C: I can read as much as I want with moderate pain in my neck
D: I cannot read as much as I want because of moderate pain in my neck.
E: I can hardly read because of severe pain in my neck.
F: I cannot read at all.

Section 5 – Headache:

A: I have no headaches at all.
B: I have slight headaches which come infrequently.
C: I have moderate headaches which come infrequently.
D: I have moderate headaches which come frequently.
E: I have severe headaches which come frequently.
F: I have headaches almost all the time.

Section 6 – Concentration:

A: I can concentrate fully when I want to with no difficulty.
B: I can concentrate fully when I want to with slight difficulty.
C: I have a fair degree of difficulty in concentrating when I want to.
D: I have a lot of difficulty in concentrating when I want to.
E: I have a great deal of difficulty in concentrating when I want to.
F: I cannot concentrate at all.

Section 7 – Work:

A: I can do as much work as I want to.
B: I can only do my usual work, but no more.
C: I can do most of my usual work, but no more.
D: I cannot do my usual work.
E: I can hardly do any work at all.
F: I cannot do any work at all.

Section 8 – Driving:

A: I can drive my car without neck pain.
B: I can drive my car as long as I want with slight pain in my neck.
C: I can drive my car as long as I want with moderate pain in my neck.
D: I cannot drive my care as long as I want because of moderate pain in my neck.
E: I can hardly drive my car at all because of severe pain in my neck.
F: I cannot drive my car at all.

Section 9 - Sleeping:

A: I have no trouble sleeping.
B: My sleep is slightly disturbed (less than 1 hour sleepless).
C: My sleep is mildly disturbed (1-2 hours sleepless).
D: My sleep is moderately disturbed (2-3 hours sleepless).
E: My sleep is greatly disturbed (3-5 hours sleepless).
F: My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation:

A: I am able to engage in all recreational activities with no pain at all.
B: I am able to engage in all recreational activities with some pain in in my neck.
C: I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D: I am able to engage in a few of my recreational activities because of pain in my neck.
E: I can hardly do any recreational activities because of pain in my neck.
F: I cannot do any recreational activities at all.

Score _____

Initial _____ Date _____

CENTER OF BRAIN AND SPINE SURGERY
JERRY BAUER, M.D., F.A.C.S.
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GEORGE K. BOVIS, M.D.

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PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

We understand that the privacy of your personal information is important to you. As your physicians, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies, please do not hesitate to ask our privacy officer Kris R, who can be reached at (847) 698-1088.

Information We Collect About You

We collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities, and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian. The Center of Brain and Spin Surgery does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

Safeguarding Your Personal and Health Information

We are required by law to 1) make sure that medical information that identifies you is kept private 2) provide you with our privacy policy 3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide service to you. The Center of Brain and Spine Surgery maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with the Center of Brain and Spine Surgery.

Changes To Our Privacy Policy

All new patients will receive a copy of our privacy. The Center of Brain and Spine occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be posted in our office and copies available at the front desk prior to the effective date of changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Acknowledged _____ **Date** _____

Initial _____ Date _____