

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_

**Patient Information**: *Name*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Date of Birth*:\_\_\_\_\_\_\_\_\_\_\_\_\_ *SSN*:\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_

*Sex*: Male / Female *Marital Status:* Married / Single / Widowed / Other

*Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Preference:* Home / Cell / Work / Email

*Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Onset of Symptoms / Date of Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury is:* Work / Fall / Motor Vehicle Accident

*Family Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us? Family / Friend / Other*

*Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other physicians you have seen for this:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Work History:** *Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Are you currently working:* Yes / No / Retired *Date you stopped working:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Is this a Work Comp Case?* Yes / No *Caseworker Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Who, other than yourself, may access your medical and/or financial record?**

*Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Insurance Information:**

*Primary Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Secondary Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Authorization to Pay Benefits to Provider:** I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider when he accepts assignment. I also understand I am financially responsible to The Nebraska Neurosurgery Group, LLC for any amounts not covered by my health insurance.

**Authorization to Release Medical Information:** I authorize my Provider to release any information necessary for my course of treatment.

**Privacy:** I acknowledge that I have received a copy of The Nebraska Neurosurgery Group, LLC HIPAA Privacy Practices.

*Patient/ Guarantor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 ***The Nebraska Neurosurgery Group Office Policies***

***New Patients*** please bring all information related to your condition, medical records, test results, MRI CD or other radiology films, and a list of your medications with the current dose and frequency. Please arrive fifteen minutes before your appointment to allow time to process your paperwork. Before you arrive please fill out the New Patient information that is mailed to you. You will need to bring a photo ID and all of your insurance cards. If time does not allow us to mail information, please arrive thirty minutes prior to your appointment time, or access the information on our web page at [www.nebraskaneurosurgerygroup.net](http://www.nebraskaneurosurgerygroup.net) Go to the forms tab and print the Health History form for your gender (male or female).

***Cancellations*** must be made twenty -four hours prior to your appointment. The Nebraska Neurosurgery Group treats patients who may have life threatening illnesses or injuries, therefore a patient who “No Shows” will be dismissed from services and referred to an office of the same specialty.

***Insurance*** The Nebraska Neurosurgery Group participates with most major insurance companies and worker’s compensation. It is the policy holder’s responsibility to contact their insurance for network participation information. We do not file liability claims nor do we wait for payment from court settlement cases. If you are working with an attorney, you are required to pay for services provided to you in full. Upon request, The Nebraska Neurosurgery Group will provide you with a statement showing your service dates and all applied payments.

***Payments*** Copays are collected prior to services being rendered. If you do not have your copay you will be asked to reschedule. As a courtesy our office will bill all clinical and hospital services our physician provides. Facilities such as hospital, radiology, and laboratory bill separately for their services. We are a Green Clinic and would like to save paper waste by inviting patients to pay their balance from the explanation of benefits (EOB). This is the mailing from your insurance company that shows how your medical claim(s) were processed and what you financial responsibility is. Payment arrangements can be made with our billing office. This office does not finance large balances. Budget payment agreements can be set up. We require a fifty dollar minimum monthly payment and will not carry a balance for more than ten months. ($1000.00 balance / 10 months=$ 100.00 monthly payment). Balances not paid over sixty days will be turned to collections. Self-pay (uninsured) patients are required to pay for clinical services in full and surgical services require a written payment contract. Our business office will go over the cost and contract with you.

**\*SMOKING AND TOBBACCO USE IS HARMFUL TO YOUR HEALTH. DISCONTINUING THE USE OF SUCH PRODUCTS WILL IMPROVE YOUR OVERALL HEALTH AND SURGICAL OUTCOME. IF YOU WOULD LIKE SUPPORT PLEASE ASK US FOR A TOBACCO FREE NEBRASKA BOOKLETT OR CALL 800-784-8669.\***

***Phone Messages*** we are open Monday to Friday 8:00 am – 5:00 pm, every effort will be made to return your call within 24 hours. Our physician’s surgery and hospital call schedule does not always allow him to be available to answer questions or refill medication immediately. After hours voice- mail is set up for you to leave NON-URGENT messages. This is NOT an answering service. **If you are experiencing a medical emergency call 911 or your local hospital.**

***Minors*** All minor children MUST be accompanied by a parent/guardian.

***Acknowledgement*** I have read, understand and agree to follow the office policies stated above.

Signature of Patient/Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_

 ****

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Female Symptom Sheet**

**Past Medical History**

Ο Anemia Ο Colon Cancer Ο Hypertension Ο Rheumatoid Arthritis

Ο Angina Ο Congestive Heart Failure Ο Kidney Failure Ο Seizure Disorder

Ο Arrhythmia Ο COPD Ο Liver Disease Ο Spinal Cord Tumor

Ο Asthma Ο Coronary Artery Disease Ο Lung Cancer Ο Thyroid Disease

Ο Atrial Fibrillation Ο Diabetes Ο Migraines Ο Tremor

Ο Blood Clots Ο Fibromyalgia Ο Multiple Sclerosis Ο Breast Cancer

Ο Brain Tumor Ο Hepatitis C Ο Parkinson’s Disease

Ο Cerebrovascular Accident Ο Peripheral Nerve Disorder

Ο Cirrhosis Ο HIV/AIDS Ο Hyperlipidemia Ο Renal Disease

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

**Past Surgical History**

Ο Anesthesia Reaction Ο Carpal Tunnel Release Ο LASIK Ο Hysterectomy

Ο Aneurysm Clipping/Resection Ο Cataract Extraction Ο Muscle Biopsy Ο Mastectomy

Ο Angioplasty w/Stent Ο Cerebral Shunt Ο ORIF Ο Myomectomy

Ο Angioplasty Ο Cholecystectomy Ο Pacemaker Ο Breast Reduction

Ο Appendectomy Ο Colectomy Ο Small Bowel Resection Ο TAH/BSO

Ο Arthroscopy Knee Ο Spinal Infusion Pump Ο Vaginal Hysterectomy

Ο Arthrodesis Ο Gastric Bypass Ο Thyroidectomy Ο Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ο Back Surgery Ο Hernia Repair Ο Tonsillectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ο CABG Ο Hip Replacement Ο Cesarean Section \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ο Carotid Endarterectomy Ο Knee Replacement Ο D and C \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Please Fill Out Both Sides of Form**

****

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Female Symptom Sheet**

**Please Mark Any Current Symptoms:**

**Constitutional Cardiovascular Reproductive Neurological Musculoskeletal**

Ο Chills Ο Chest Pain Ο Abnormal Pap Ο Dizziness Ο Back pain

Ο Fatigue Ο Claudication Ο Dysmenorrhea Ο Extremity Numbness Ο Joint Pain

Ο Fever Ο Edema (cramps) Ο Extremity Weakness Ο Joint Swelling

Ο Malaise (discomfort) Ο Palpitations Ο Dyspareunia Ο Gait Disturbance Ο Muscle Weakness

Ο Night Sweats (painful intercourse) Ο Headache Ο Neck Pain

Ο Weight Gain **Gastrointestinal** Ο Hot Flashes Ο Memory Loss

Ο Weight Loss Ο Abdominal Pain Ο Irregular Menses Ο Seizures **Hematologic/Lymphatic**

 Ο Blood in Stools Ο Vaginal Discharge Ο Tremors Ο Easy Bleeding

**HEENT** Ο Constipation Ο Easy Bruising

Ο Ear Drainage Ο Diarrhea **Integumentary Psychiatric** Ο Lymphadenopathy

Ο Ear Pain Ο Heartburn Ο Breast Discharge Ο Anxiety(Lymph Node Disease)

Ο Eye Discharge Ο Loss of Appetite Ο Breast Lump Ο Depression

Ο Eye Pain Ο Nausea Ο Brittle Hair Ο Insomnia **Immunologic**

Ο Hearing Loss Ο Vomiting Ο Brittle Nails Ο Contact Allergy

Ο Nasal Drainage Ο Hair Loss **Metabolic/Endocrine** Ο Environmental allergy

Ο Sinus Pressure **Genitourinary** Ο Hirsutism Ο Cold Intolerance Ο Food Allergies

Ο Sore Throat Ο Dysuria (excessive hair) Ο Heat Intolerance Ο Seasonal Allergy

Ο Visual Changes (painful urination) Ο Hives Ο Polydipsia Ο Hematuria Ο Pruritus (excessive thirst)

**Respiratory** (blood in urine) (itching of skin) Ο Polyphagia

Ο Chronic Cough Ο Polyuria (excess Ο Mole Changes (excessive hunger)

Ο Cough secretion of urine) Ο Rash

Ο Known TB Exposure Ο Urinary Frequency Ο Skin Lesion **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Ο Shortness of Breath Ο Urinary Incontinence \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ο Wheezing Ο Urinary Retention \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain**

Mark the areas on the body where you feel any aching,

numbness, burning, stabbing, or pins and needles.

Rate your pain on a scale from 0-10

10 being the worst:

0 1 2 3 4 5 6 7 8 9 10

Height\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_

Do you wear a devise for sleep apnea? Circle one

YES NO

**\*Please fill out both sides of form**

 **Front Back**

 Right Left Left Right

 



**Health History**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History**

Please list any **health problems** in your family members, including cause of death if deceased.

 **Health Problems** Still Living?

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

**Social History**

**Do you use Nicotine / Tobacco Products?**  No, I never have

 No, I stopped in \_\_\_\_\_\_\_\_ How much did you use? \_\_\_\_\_\_\_\_\_ packs/cans/cigars per day for \_\_\_\_\_\_\_\_ years.

 Yes, I do \_\_\_\_\_\_\_\_ packs/cans/cigars per day for \_\_\_\_\_\_\_\_ years.

**Alcohol Use:**  None Stopped in\_\_\_\_\_\_\_ Yes, I do Amount per day \_\_\_\_\_\_\_\_\_, Type used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Illegal Drug Use:**  None Only in the past Yes, I do Over the Counter or Prescription Drug Abuse

Types of Drugs Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any History of Illegal IV Drug Use? Yes No Current IV Drug Use? Yes No

**Do you Exercise?**  Yes No If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you LEFT HANDED or RIGHT HANDED? Any Falls in the last year? YES or NO; Fall result in injury? YES or NO**

**Which Pharmacy do you use?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

**Name / Dose**

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

**Medication Allergies** I have NO known drug allergies **Iodine / Shellfish / Latex Allergy Yes No**

**Allergy / Reaction**

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