

**PATIENT INFORMATION SHEET (PLEASE PRINT)**

Chart Location:	Chart Number:
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<b>PATIENT INFORMATION</b>	DATE:	REFERRED BY (PCP):	HAVE WE SEEN ANYONE ELSE IN THE FAMILY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME:			
	PATIENT NAME: LAST:	FIRST:	MIDDLE:	DATE OF BIRTH:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
	HOME ADDRESS:		SOCIAL SECURITY NUMBER:		MARITAL STATUS:	
	CITY:	STATE:	ZIP CODE:	HOME PHONE NUMBER:	CELL/PAGER NUMBER:	
	EMPLOYER:	OCCUPATION:	EMPLOYER PHONE NUMBER:			
	RESPONSIBLE PARTY NAME:		RELATIONSHIP TO PATIENT:	RESPONSIBLE PARTY SOCIAL SECURITY:		
	RESPONSIBLE PARTY ADDRESS:		CITY:	STATE:	ZIP CODE:	
	RESPONSIBLE PARTY EMPLOYER:		RESPONSIBLE PARTY WORK PHONE:		OCCUPATION:	
	SPOUSE NAME:	SPOUSE SOCIAL SECURITY NUMBER:	SPOUSE EMPLOYER:	SPOUSE WORK PHONE:		
	EMERGENCY CONTACT:	RELATIONSHIP TO PATIENT:	HOME PHONE NUMBER:	WORK PHONE NUMBER:		

<b>INSURANCE PRIMARY</b>	INSURANCE COMPANY NAME:	GROUP NUMBER:	EMPLOYER OF POLICY HOLDER:		
	POLICY HOLDER NAME:	POLICY HOLDER SS # OR I.D. #:	POLICY HOLDER BIRTHDATE:	RELATIONSHIP TO PATIENT:	
	INSURANCE COMPANY MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:	INSURANCE CO. PHONE #:

If no secondary insurance circle: **NONE**

<b>INSURANCE SECONDARY</b>	INSURANCE COMPANY NAME:	GROUP NUMBER:	EMPLOYER OF POLICY HOLDER:		
	POLICY HOLDER NAME:	POLICY HOLDER SS # OR I.D. #:	POLICY HOLDER BIRTHDATE:	RELATIONSHIP TO PATIENT:	
	INSURANCE COMPANY MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:	INSURANCE CO. PHONE #:

I give my consent to Neurosurgery & Spinal Disorders, P.A. to speak to anyone at the above referenced telephone numbers. \_\_\_\_\_ (INITIALS)

**AUTHORIZATION AND CONSENT FOR HEALTH CARE**

I hereby authorize the physician, Shah N. Siddiqi, M.D., and affiliated or other providers to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to the physicians of Neurosurgery & Spinal Disorders, or other providers for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if Neurosurgical & Spinal Disorders is unable to verify eligibility, that I am responsible for all charges incurred for services rendered.

I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatments by my physicians, and my physician's associates, assistants, and other healthcare providers, as may be necessary in my physician's judgement. I have relied on my physicians for information in this regard and acknowledge that no warranty or guarantee has been made to me as to result or cure. This form has been fully explained to me, and I certify that I understand its contents.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

**Update Confirmation (No Changes Necessary)**

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

## MEDICAL HISTORY

PATIENT NAME:				DATE:
AGE:	TEMPERATURE:	BLOOD PRESSURE:	PULSE:	RESPIRATION:
REFERRING DOCTOR:				
REFERRING DOCTOR ADDRESS:			REFERRING DOCTOR PHONE:	

**TO THE PATIENT:** This information will be placed in your confidential medical record. It is important to complete each section to the best of your knowledge. If you are uncertain of dates, give approximate dates.

CHIEF COMPLAINT:

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PRESENT ILLNESS (PLEASE DESCRIBE IN DETAIL):

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**PAST MEDICAL HISTORY** Check (✓) any/all problem(s) that you have experienced:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Knocked Unconscious | <input type="checkbox"/> Depression       | <input type="checkbox"/> Thyroid        |
| <input type="checkbox"/> Encephalitis    | <input type="checkbox"/> Paralysis           | <input type="checkbox"/> Polio            | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Meningitis      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> TB               | <input type="checkbox"/> Memory Loss    |
| <input type="checkbox"/> Convulsions     | <input type="checkbox"/> Ulcer Disease       | <input type="checkbox"/> Blood Disorder   | <input type="checkbox"/> Eye Problem    |
| <input type="checkbox"/> Back Pain       | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Cancer           |   |
| <input type="checkbox"/> Neck Pain       | <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Venereal Disease |   |
| <input type="checkbox"/> Arm Pain        | <input type="checkbox"/> Nervous Breakdown   | <input type="checkbox"/> Urinary          |   |

**COMPLETE REVIEW OF SYSTEMS** Explain any difficulty or problem that you have had with any system listed below:

Head / Eyes / Ears / Nose / Throat: \_\_\_\_\_

Chest / Lungs: \_\_\_\_\_

Heart / Vascular: \_\_\_\_\_

Abdomen / Intestines / Liver: \_\_\_\_\_

Urinary System / Genital System: \_\_\_\_\_

Musculoskeletal (Joints / Muscles): \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

List all drug/medication allergies:

Drug	Type of reaction

Are you allergic to seafood? \_\_\_\_\_

Past Family History:

Relative	Living/Dead	Approx. Age	Diseases or Diagnosis
Mother			
Father			
Brothers			
Sisters			

Do any members of your family have hereditary (inherited) diseases:

(Circle one) No Yes

If yes, name of the Disease(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Social History:

Circle One

Married Widowed Divorced Separated Single Live-In

Occupation \_\_\_\_\_

(If retired, Last occupation) \_\_\_\_\_

Do you smoke \_\_\_\_\_ Do you use any alcohol \_\_\_\_\_

Do you have any children \_\_\_\_\_

If so, How many \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

# Neurosurgery & Spinal Disorders, P.A.

## Patient Questionnaire

Please Print

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis.

\_\_\_\_\_

\_\_\_\_\_

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

\_\_\_\_\_

\_\_\_\_\_

3. Please print the address of where you would like your billing statements and/or correspondence from our office sent if other than your home.

\_\_\_\_\_

\_\_\_\_\_

4. Please indicate if you want all your correspondence sent from our office in a sealed envelope marked "CONFIDENTIAL."

\_\_\_\_\_ YES \_\_\_\_\_ NO

5. Please print the telephone number, if any, where you want to receive calls about your appointments, labs, and or x-ray results or other health care information if other than your home phone number.

(\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

6. Can confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail?

\_\_\_\_\_ YES \_\_\_\_\_ NO

7. If you do not have voicemail, can confidential messages be left at your place of employment?

\_\_\_\_\_ YES \_\_\_\_\_ NO

PATIENT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Guardian if under 18)