

COLUMBIA NEUROSURGICAL ASSOCIATES, P.A.

(803) 462-0423

720 Rabon Road
Columbia, S.C. 29203

132 Sunset Court
W.Cola, SC 29169

FEDERAL LAW REQUIRES ALL HEALTHCARE PRACTICES TO OBTAIN, VERIFY AND RECORD INFORMATION THAT IDENTIFIES EACH NEW PATIENT. Practice policy, therefore, requires us to record in your account with us a copy or scan of your photo I.D. for identification purposes for your protection.

You have been scheduled for an appointment at _____ on _____ . Please arrive 30 min prior to your appointed time. Patients arriving late may be rescheduled.

To avoid having your appointment rescheduled, please make certain you bring all of the following items listed below:

- All paper work completed (front and back of forms) and signed before your arrival in the office; Be certain to include all of your current medicines.**
- All x-rays, CT and MRI films and reports pertaining to this visit . Your referring doctor will send medical records only, NOT your films. It is the patient's responsibility to bring all films for this appointment.**
- All insurance cards and forms that may aid in filing your claims, prescription cards and a picture ID to be copied and placed in your chart.**
- Co-pays will be collected by the receptionist at check-in on each visit. Deductibles will be collected at check-out. There is a fee charged for the completion of disability and FMLA forms.**

Children are not allowed in exam rooms and can not be left unattended in the lobby.

Cells phone must be turned off or to vibrate while in exam rooms.

Please do not wear perfumes or scented lotions to your appointment.

ALL SECTIONS ON BOTH SIDES MUST BE COMPLETED

<input type="checkbox"/> N.E	COLUMBIA NEUROSURGICAL ASSOCIATES, P.A.	LEX. <input type="checkbox"/>
PATIENT REGISTRATION		
<input type="checkbox"/> Holbrook	<input type="checkbox"/> Rambo	<input type="checkbox"/> Boyd
<input type="checkbox"/> Gunter	<input type="checkbox"/> Drye	<input type="checkbox"/> Lozanne
<input type="checkbox"/> Storick	<input type="checkbox"/> Rawl	

Chart number:	Date:
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A. PATIENT INFORMATION				PLEASE PRINT	
Last Name:		First Name:		Middle Initial:	
Street Address:				Home Phone: ()	
City:	State:	Zip:	County:	Social Security Number:	
Birth Date: (mm/dd/yy)		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	
Cell Phone:	Work Phone:	Ext:	Email:		
Pharmacy Name:	Address:		Phone:		
Emergency Contact Other Than Home:					
Name:			Phone: ()		
Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Friend <input type="checkbox"/> Other					
Employer Name, Address & Phone:				Occupation:	

B. NAME OF PHYSICIAN THAT REFERRED YOU TO US	
Name:	Phone: ()
Address:	
Primary Care Physician:	Phone: ()

C. INSURANCE INFORMATION	
1st Insurance Name:	2nd Insurance Name:
Does Ins. Require: <input type="checkbox"/> Pre-Authorization <input type="checkbox"/> Referral	Does Ins. Require: <input type="checkbox"/> Pre-Authorization <input type="checkbox"/> Referral
Group # : Policy Id #	Group # : Policy Id # :
Policyholder DOB:	Policyholder DOB:
Relationship to Patient:	Relationship to Patient:
Policyholder Name:	Policyholder Name:
Policyholder Employer:	Policyholder Employer:

D. HAS PATIENT BEEN TREATED BY ANY COLUMBIA NEUROSURGICAL PHYSICIAN BEFORE?	
If yes, approx when?	Which physician?

ALL SECTIONS ON BOTH SIDES MUST BE COMPLETED

E. WERE YOU INJURED ON THE JOB:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE OF INJURY:
WERE YOU IN AN AUTO ACCIDENT:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE OF INJURY:

F. ATTORNEY INFORMATION (if applicable)			
Attorney Name:			
Address:			
City :	State:	Zip Code :	Phone : ()

G. RESPONSIBLE PARTY (if different from patient)			
Last Name:	First Name:	Middle Initial:	
Address:		Home Phone: ()	
City:	State:	Zip:	Work Phone: () Ext.
Relationship to Patient:	<input type="checkbox"/> Parent	<input type="checkbox"/> Spouse	<input type="checkbox"/> Guardian <input type="checkbox"/> Friend <input type="checkbox"/> Other

H. AUTHORIZATION AND CONSENT	
<p>I authorize reports of my evaluation, treatments and any follow-up evaluations to be sent to my referring doctor, the doctor requesting consultation, my family physician, as well as any other health care providers, hospitals or outpatient facilities that I have or will identify to you. I understand the disclosed information may include information and records protected by Federal Law (such as alcohol and drug treatment) and/or State Law (such as mental health, AIDS, or HIV).</p> <p>I authorize Columbia Neurosurgical Assoc. P.A. to release to the Social Security Administration and The Centers for Medicare and Medicaid Services or its intermediaries or carriers or to the billing agents of my insurance companies or to my employer and its agents for Workers' Compensation claims any medical or financial information needed for payment of my medical claims.</p> <p>I authorize the assignment of all medical and procedural benefits to which I am entitled to Columbia Neurosurgical Assoc. P.A. and I permit a copy of this authorization to be used in place of the original.</p> <p>I understand it is my responsibility to pay my co-pay or co-insurance per my insurance contract at each office visit. I understand and agree that if the amount of my co-pay or co-insurance can not be determined, I will pay 20% of the office charge as a down payment for services rendered. Once insurance has paid, I understand that I will be responsible for any unpaid balance. Any credit balances will be refunded to me. I understand and agree that if Columbia Neurosurgical Assoc. P.A. is out of network for my insurance company or if I am not covered by health insurance, I will pay the charge in full for all services rendered at the time they are rendered unless previous financial arrangements have been made.</p>	
Signature of Patient or Personal Representative	Date: _____
Description of Personal Representative's Authority (attach necessary documentation)	

I. ACKNOWLEDGEMENT	
I acknowledge Columbia Neurosurgical Assoc. P.A.'s Notice of Privacy Practices has been made available to me.	
Signature of Patient or Personal Representative	Date: _____
Description of Personal Representative's Authority (attach necessary documentation)	

Authorization for Release of Information

Chart No: _____

Name of Patient _____ Date of Birth _____

COLUMBIA NEUROSURGICAL ASSOCIATES, P.A. is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Spouse (check if you approve to receive information) (provide name) _____	<input type="checkbox"/> All <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows:
<input type="checkbox"/> Parent (check if you approve to receive information) (provide name) _____	<input type="checkbox"/> All <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows:
<input type="checkbox"/> Other (provide name) _____	<input type="checkbox"/> All <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows

Patient Information

I understand the disclosed information may include information and records protected by Federal Law (such as alcohol and drug treatment) and/or State Law (such as mental health, AIDS, or HIV).

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Date _____

Signature of Patient or Personal Representative
 Description of Personal Representative's Authority (attach necessary documentation)

COLUMBIA NEUROSURGICAL ASSOCIATES, P.A.

Please complete this medical questionnaire. The answers to these questions are very important in helping us take care of you. Where appropriate, fill in complete answers. Thank-you for your time and patience.

Name: _____ M / F Date of Visit: _____
(circle one)

Age: _____ Height _____ Weight: _____ Date of Birth: _____

Referring Doctor: _____ Family Doctor: _____

1. I am () right handed () left handed.

2. Chief complaint or reason for visit: _____

3. When did your symptoms first appear? _____

4. Did you have an injury? () Yes () No If yes, was it work related? () Yes () No () Other _____

5. I have been treated for this problem by: _____

6. What did they do or recommend? _____

7. My medication allergies are: () None or list allergies: _____

8. My current medications are: (include dose and # of times taken per day) _____

9. PAST MEDICAL HISTORY: List prior injuries & illnesses, conditions, medical problems that you have (ex: diabetes, high blood pressure, heart disease) Write HOSP. beside any for which you were admitted to the hospital.

Approx. date	Reason (Give Diagnosis of problem if known)
_____	_____
_____	_____
_____	_____

10. PAST SURGICAL HISTORY: List all surgeries, even if done as an outpatient:

Approx. date	Reason
_____	_____
_____	_____
_____	_____

11. SOCIAL HISTORY: Check box or fill in blank:

() I do not use tobacco. () I do use tobacco; _____ packs/per day
 () I do not use beer, wine or liquor. () I do use beer, wine or liquor () daily () weekly () monthly
 I am () married () widowed () divorced () single Years of formal education _____
 I have () children, ages: _____
 I work as a _____ for _____
 () I have been disabled since _____ due to (list reason) _____

12. FAMILY HISTORY: Please list any illness that your grand parents, parents, brothers, sisters or children have had. (for example: cancer, diabetes, heart disease, high blood pressure, stroke)

Grand Mother _____ Grand Father _____
 Mother _____ Father _____
 Sister _____ Brother _____
 Children _____

13. SYSTEMS REVIEW: Please check any that apply to you:

Constitutional: _____ Fever in last 72 hrs. _____ hot or cold spells
 _____ generalized weakness _____ generalized lack of energy
 _____ unplanned weight loss _____ lbs over _____ months
 _____ Other: _____

Eyes: _____ declining vision _____ blurred vision _____ double vision _____ seeing spots of light
 _____ black areas in field of vision _____ eye disease (cataracts, glaucoma, etc.) _____
 _____ Other: _____

Ear Nose, Mouth Throat:

- ear aches
- frequent nosebleeds
- mouth/throat cancer
- decreased hearing
- chronic sinus
- voice changes or hoarseness
- ringing in ears
- mouth ulcers

Other: _____

Cardiovascular:

- chest pain () sharp () dull () happens only when exercising
- history of heart attack
- palpitations
- shortness of breath
- I have a pacemaker
- heart surgery or catheterization
- heart murmur
- () happens only when exercising
- heart rhythm disturbance

Other: _____

Respiratory:

History of:

- pneumonia
- asthma
- I cough up blood from time to time
- bronchitis
- emphysema
- tuberculosis
- lung cancer

Other: _____

Gastrointestinal:

- difficulty swallowing
- stomach ulcers
- diarrhea
- stomach or bower cancer
- bulimia
- hernia
- nausea/vomiting last 48hrs
- heart burn
- change in appetite
- liver disease
- anorexia
- hepatitis

Other: _____

Genitourinary:

- frequent urinary tract infection
- blood in urine
- miscarriage
- difficulty urinating
- prostate problems
- venereal disease : () gonorrhea () herpes () syphilis
- painful urination
- vaginal infections

Other: _____

Musculoskeletal:

- joints that dislocate
- arthritis
- back pain
- back pain is relieved completely when I lie down
- back pain is relieved mostly when I lie down
- Lying down does not help my back pain
- neck pain () right side () left side () both sides
- arm pain () right () left () both
- leg or ankle swelling
- gout
- leg pain () right () left
- fractures
- osteoporosis
- polio

Integumentary:

- skin rashes
- skin cancer- Type: _____
- breast disease _____

Neurological:

- headaches: How often _____
- fainting spells
- confusion
- history of head trauma
- facial numbness
- multiple sclerosis
- numbness in hands or arms
- difficulty using hands
- difficulty walking/numbness in legs
- with nausea
- history of migraines
- declining memory
- history of brain tumor
- dizziness
- epilepsy
- () right () left () both
- () right () left () both
- () right () left () both
- with blurred vision

Psychiatric:

- I have been treated/hospitalized for:
- schizophrenia
- alcoholism
- depression
- chemical dependency
- suicide attempt

Endocrine:

- thyroid
 - goiter
 - diabetes
- I take the following hormone supplements: _____

Hematologic/lymphatic:

- bleeding disorder easy bruising anemia
- tendency to form blood clots in legs swollen lymph nodes
- Aids HIV

Immunologic:

- Lupus Scleroderma Rheumatoid arthritis

Other:

- chicken pox measles mumps Mononucleosis
- scarlet fever whooping cough typhoid fever rheumatic fever

14. If you have back, leg, neck or arm pain , please answer the following:

- I have taken physical therapy in the last 6 months for this problem
- I have taken medicines like Motrin, Aleve, muscle relaxants or pain medicine to help relieve the pain.
- I have had steroid injections in my back or neck for this problem.

Rate the severity of your pain on a scale from 1 to 10, with 1 the least painful and 10 being the most severe. _____

Type of pain:

- sharp dull throbbing aching shooting burning
- tingling numbness stiffness swelling cramps

Other: _____

the pain comes and goes If so, how often do you have this pain? _____

the pain is constant

Does the pain interfere with work sleep daily routine recreation

Activities or movements that are painful to perform:

- sitting standing walking bending lying down
- How do you sleep? back side stomach

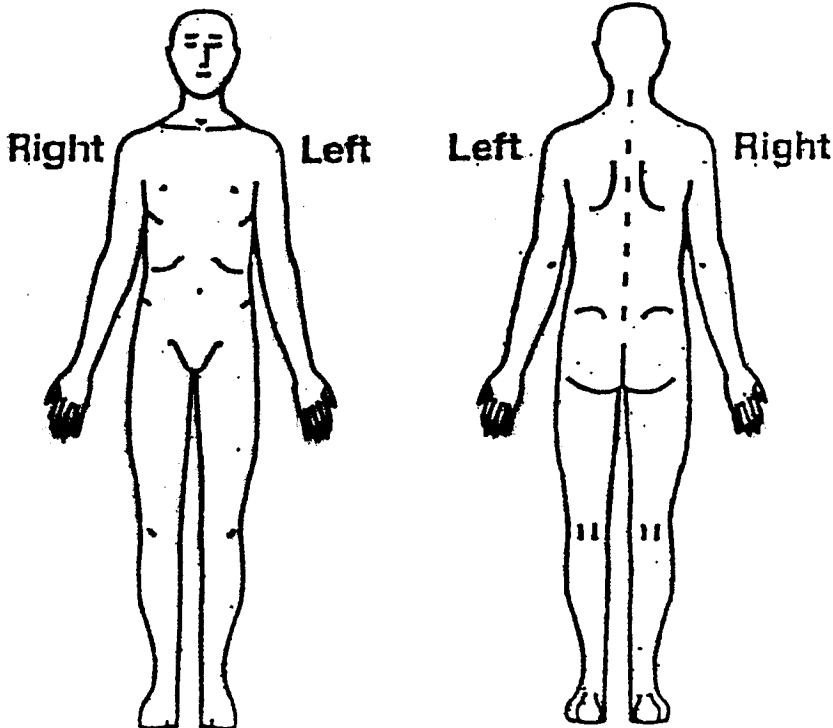
15. Date of your last:

- Physical exam _____ Spinal exam _____ MRI, CT or Bone Scan _____
- Spinal X-ray _____ Chest x-ray _____ Blood test _____

16. I am claustrophobic (fear of being in a closed/confined place) () Yes () No

I have metal in my body. () Yes () No If yes, where? _____

Mark an X on the picture where you have pain, numbness or tingling.



Patient Signature

Physician Signature

Date