

**NEUROSURGERY ASSOCIATES REGISTRATION PAGE 1 of 5**

**FOR OFFICE USE ONLY**

Date filled out: \_\_\_\_\_ ACCOUNT NO. \_\_\_\_\_

REVIEWED \_\_\_\_\_

For follow-up visits, if necessary, we will ask that you update this form.

Date of revision 1: \_\_\_\_\_

REVIEWED \_\_\_\_\_

Date of revision 2: \_\_\_\_\_

REVIEWED \_\_\_\_\_

Date of revision 3: \_\_\_\_\_

REVIEWED \_\_\_\_\_

**PATIENT INFORMATION**

Pronunciation of your name as best you can describe it to us \_\_\_\_\_  
(For example, "Cry key" for Kreyke)

Nickname which you wish us to use, for example, "Dick" for "Richard" \_\_\_\_\_

Occupation: \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Sex (M/F) \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cellular/Mobile phone (important if you own one): \_\_\_\_\_

E-mail address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

**REFERRING PHYSICIAN**

Physician's Name \_\_\_\_\_ Practice Name \_\_\_\_\_

Street Address \_\_\_\_\_ Suite/Bldg. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Bus. Phone \_\_\_\_\_

**FAMILY PHYSICIAN (if different from above)**

Physician's Name \_\_\_\_\_ Practice Name \_\_\_\_\_

Street Address \_\_\_\_\_ Suite/Bldg. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Bus. Phone \_\_\_\_\_

**EMPLOYER INFORMATION**

Company Name \_\_\_\_\_

Street Address \_\_\_\_\_ Suite/Bldg. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Bus. Phone \_\_\_\_\_

**INSURANCE INFORMATION - Please note that copayments are due at time of visit**

PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

Name of Insurance Co. (Primary) \_\_\_\_\_ Address \_\_\_\_\_

Group No. \_\_\_\_\_ Policy/Certificate No. \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Name of Insurance Co. (Additional) \_\_\_\_\_ Address \_\_\_\_\_

Group No. \_\_\_\_\_ Policy/Certificate No. \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

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**PARENT/SPOUSE/GUARDIAN INFORMATION - FINANCIAL RESPONSIBILITY**

Name of Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Sec. No. \_\_\_\_\_ Home Phone \_\_\_\_\_

Employers Name \_\_\_\_\_ Occupation \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**NEAREST RELATIVE OR FRIEND NOT LIVING WITH PATIENT (to be contacted in the event of an emergency)**

Name of Relative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Business or Cell Phone \_\_\_\_\_

**WORKER'S COMPENSATION INFORMATION - Complete this section ONLY if injury is WORK RELATED**

Date of Injury \_\_\_\_\_ Date Last Worked \_\_\_\_\_ Have you seen another physician for this injury? \_\_\_\_\_

If yes, whom? \_\_\_\_\_ Address \_\_\_\_\_

Name of Employer (when injured) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Business Phone \_\_\_\_\_

Name of Worker's Compensation Insurance \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Business Phone \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Claim Number \_\_\_\_\_

Name of Attorney (if involved) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Business Phone \_\_\_\_\_

**OTHER PERSONAL INJURY - Complete this section only if condition is caused by an accident and is not work related.**

Date of Injury \_\_\_\_\_ Type of Accident: Auto \_\_\_\_\_ Assault \_\_\_\_\_ Slip & Fall \_\_\_\_\_ Other \_\_\_\_\_

Name of Responsible Insurance \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Business Phone \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Claim Number \_\_\_\_\_

Name of Attorney (if involved) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Business Phone \_\_\_\_\_

**PERSONAL INFORMATION**

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Are you married? \_\_\_\_\_ If so, name of spouse \_\_\_\_\_

Do you have children? \_\_\_\_\_ If so, names, ages, and phone numbers (if adults)

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**FAMILY INFORMATION**

Is your father alive? \_\_\_\_\_ If not, approximate age and cause of death \_\_\_\_\_

Does he have any significant medical problems? \_\_\_\_\_

Is your mother alive? \_\_\_\_\_ If not, approximate age and cause of death \_\_\_\_\_

Does she have any significant medical problems? \_\_\_\_\_

**PHARMACY**

Name and phone number of your pharmacy.

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HAVE YOU EVER SEEN ANOTHER NEUROSURGEON? IF SO, NAME AND APPROXIMATE YEAR OF VISIT.

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**ALLERGIES TO ANY MEDICATIONS? \_\_\_\_\_ IF SO, WHICH? \_\_\_\_\_**

**DESCRIBE ALLERGIC REACTION \_\_\_\_\_**

DO YOU SMOKE? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, HOW MUCH? \_\_\_\_\_

DO YOU DRINK? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, HOW MUCH AND OFTEN? \_\_\_\_\_

**COMPLETE LIST OF ALL MEDICATIONS, INCLUDING DOSE AND TIMES TAKEN (IMPORTANT)**

NAME OF MEDICATION (include vitamins, supplements & over the counter medications)	DOSE AND HOW MANY TIMES A DAY (example: 200 mg three times a day)

Please ask for additional page from receptionist if there are additional medications.

Please indicate YES or NO if you currently experience any of the following symptoms:

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	YES	NO		YES	NO		YES	NO
<b>CHEST/HEART/LUNGS</b>			<b>GASTROINTESTINAL</b>			<b>EARS</b>		
Shortness of Breath			Indigestion or Heartburn			Ear Pain		
Poor Exercise Tolerance			Vomiting			Drainage from Ear		
Fluttering of Heart			Abdominal Pain/ Cramps			Sinus Trouble		
Unusual Heartbeat			Abdominal Swelling					
Chest Pain			Diarrhea			<b>SKIN</b>		
New cough of any kind			“BM” is bowel movement			Changing Mole		
Coughing Up Blood			Change in Bowel Habits			Rash		
High Blood Pressure			Passing Blood with BM			Psoriasis		
Angina			Black, Tarry BM			Other Skin Problem		
Rheumatic Fever			Gallstones					
Varicose Veins			Hepatitis			<b>ENDOCRINE</b>		
Wheezing			Cirrhosis of the Liver			Always Feel Cold		
Prior Heart Attack			Stomach/Duodenal Ulcer			Always Hot/Warm		
Heart Murmur			Hemorrhoids			Always Tired/Sluggish		
Enlarged Heart			Nausea			Diabetes		
Abnormal Chest X-ray						Gout		
Abnormal EKG			<b>NEUROLOGICAL</b>			Goiter		
Asthma			Severe Headaches			Night Sweats		
Emphysema			Blurred Vision			Overactive Thyroid		
History of DVT			Double Vision			Underactive Thyroid		
History of PE			Dizziness/Fainting Spells			Nervousness		
			Difficulty With Balance			Marked Weight Gain		
<b>BONES AND JOINTS</b>			Poor Muscle Strength			Marked Weight Loss		
Arthritis			Arm Weakness			Irregular Periods		
Painful Joints			Leg Weakness			Absent Periods		
Polio			Light Flashes			Change in (Ring Size, Hat Size, Shoe Size)		
Swollen Joints			Difficulty Hearing			Milky Discharge From Breasts		
Back Pain			Difficulty Swallowing					
Neck Pain			Persistent Hoarseness					
			Speech Difficulty			<b>PSYCHIATRIC</b>		
<b>GENITOURINARY</b>			Buzzing/Ringing in Ears			Severe Depression		
Blood in Urine						Hospitalization for		
Pain/Burning w/Urine						Psychiatric Problems		
Difficulty Passing Urine								
Trouble Controlling Urine			<b>HEMATOLOGIC</b>			<b>CANCER</b>		
Kidney Stones			Easy Bruising			Explain Below		
Prostate Trouble			Nosebleeds (not due to injury)					
			Poor Blood Clotting					
			Swollen Glands					
			Unexplained Fevers					
			Chills					

PLEASE LIST ANY PRIOR SURGERIES BELOW:

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SURGERY TYPE	DATE (APPROXIMATE)

Have you ever had problems with anesthesia? Yes\_\_\_\_NO\_\_\_\_

If yes, please explain\_\_\_\_\_

Have you ever had problems with wound healing? Yes\_\_\_\_NO\_\_\_\_

If yes, please explain\_\_\_\_\_

PLEASE READ AND SIGN THE FOLLOWING:

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to referring/family physicians and to any insurance company if applicable. I allow facsimile transmittal of my medical records, if necessary. I acknowledge full financial responsibility for services rendered. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges, by my insurance company or other responsible party. I further authorize and request that insurance payments be made directly to STEPHEN SARIS, M.D. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature\_\_\_\_\_Date\_\_\_\_\_

Relationship (if other than patient)\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can & will be used to conduct, plan & direct my treatment & follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third-party payers and conduct normal healthcare operations such as quality assessments & physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses & disclosures of my health information. I understand that Neurosurgery Associates has the right to change its Notice of Privacy Practices from time to time & that I may contact Neurosurgery Associates at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree, then you are bound to abide by such restrictions.

Patient Signature:\_\_\_\_\_Date\_\_\_\_\_

FOR OFFICE USE

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so:

DATE:	INITIALS	REASON:
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