NEUROSURGERY

PATIENT INFORMATION

Age _____ Sex M ☐ F ☐ Date _____

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Date of Birth _____

Email _____ Social Security # _____ Race _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other _____

Occupation _____ Drivers License # _____ State _____

Employer _____ Employer Phone # _____

Employer Address _____

In Case of Emergency, Notify _____ Relationship to Patient _____

Emergency Contact Phone # _____ ☐ Cell ☐ Home ☐ Work

Spouse Name _____ Spouse Phone # _____ ☐ Cell ☐ Home ☐ Work

Pharmacy Name/Location _____ Phone # _____

Is Your Visit Related to An Accident? ☐ Yes ☐ No If so, Date of Injury/Accident _____

Do you have an Advance Directive? ☐ Yes ☐ No If yes, Name of Your Decision Maker _____

INSURANCE INFORMATION

Responsible Party (check one) ☐ Self ☐ Other _____

Primary Insurance _____ ID/Policy # _____

Subscriber Name _____ ☐ Self ☐ Spouse ☐ Parent Subscriber Employer _____

Subscriber Social Security # _____ DOB _____ Group # _____

Secondary Insurance _____ ID/Policy # _____

Subscriber Name _____ ☐ Self ☐ Spouse ☐ Parent Subscriber Employer _____

Subscriber Social Security # _____ DOB _____ Group # _____

Insurance information and authorization -- Copy of Card REQUIRED

I request that payment of authorized benefits by made payable to Steven Brown, MD, Christopher Eddleman, MD, Leslie Pickett Hutchins, MD, or Talmadge Trammell, MD for services provided to me. I also authorize the release of any medical information requested by my insurance.

Person Responsible for Payment _____

Signature Required _____

Referring Physician _____ City _____

Family Physician _____ City _____

Cardiologist _____ City _____

NEUROSURGERY

Name _____ **Height** _____ **Weight** _____ **DOB** _____ **Date** _____

MEDICAL HISTORY **Chief Compliant / Reason for Referral**

☐ Brain ☐ Neck ☐ Arm(s) ☐ Back ☐ Leg(s) ☐ Carpel Tunnel

☐ Ulnar Nerve ☐ Other _____

When did your symptoms begin? _____

PHYSICIANS / TESTING List any other physicians you have seen for this issue and tests you have had.

Physicians

_____

_____

_____

_____

☐ EMG (nerve study)

☐ MRI ☐ Myelogram

☐ CT ☐ Other _____

TREATMENTS Have you had any of the following treatments for this issue in the past year?

☐ ESI (epidural steroid injection) ☐ Chiropractor ☐ Medications

☐ Physical Therapy ☐ Massage Therapy

☐ Other _____

REVIEW OF SYSTEMS **Have you had or are you having problems with any of the following related to your current condition? (Circle all that apply)**

Fever	Weight loss	Weight gain	Sore Tongue
Rashes	Changes in vision	Shortness of breath	Chest pain
Nausea/vomiting	Back pain	Neck pain	Memory problems
Abdominal pain	Pain on urination	Depression	Headache

Other _____

Name _____ Date _____

PAST SURGERIES include dates:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

MEDICATIONS *Also include non-prescription drugs with dosages* ☐ None

1. _____ 7. _____

2. _____ 8. _____

3. _____ 9. _____

4. _____ 10. _____

5. _____ 11. _____

6. _____ 12. _____

DRUG ALLERGIES

Allergic to shellfish or x-ray dye? ☐ Yes ☐ No

Latex allergy? ☐ Yes ☐ No

List allergy and reactions ☐ **No Known Drug Allergies**

1. _____ 3. _____

2. _____ 4. _____

PAST MEDICAL HISTORY **Circle any of the following medical problems for which you are currently being treated or have been treated in the past: (Circle all that apply)**

Diabetes	Heart disease	High blood pressure	Asthma/COPD
Positive HIV/AIDS	Seizure	Stroke	Head injury
Liver problems	Spine/back problems	Thyroid problems	Cancer
Kidney problems	Bleeding issues	Have you ever had a blood transfusion? ☐ Yes ☐ No	

Other _____

Name _____ Date _____

FAMILY HISTORY

Is your mother living? ☐ Yes ☐ No

If "Yes", give her age and state of health _____

If "No", give the age and cause of death _____

Is your father living? ☐ Yes ☐ No

If "Yes", give his age and state of health _____

If "No", give the age and cause of death _____

Please circle any medical problems involving your immediate and extended family:

Cancer Brain Tumor Aneurysm Seizures

Other _____

SOCIAL HISTORY

Do you use tobacco products (including e-cigarettes)? ☐ Yes ☐ No

Amount/How often? _____

For how long? ☐ Former ☐ Quit ☐ Never

Do you drink alcohol? ☐ Yes ☐ No Amount/How often? _____

OTHER

Have you had any falls in the past 12 months that required medical assistance?

☐ Yes ☐ No

Please sign and date below. (If completed by anyone other than the patient, sign and indicate your relationship to the patient.)

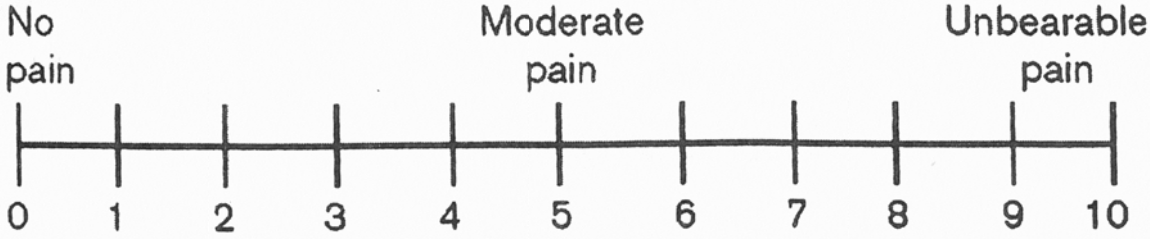
Signature _____ *Date* _____

Relationship to patient _____

List below anyone (including relationship to you) whom you give permission to access your medical records or to discuss your care with the physician or staff:

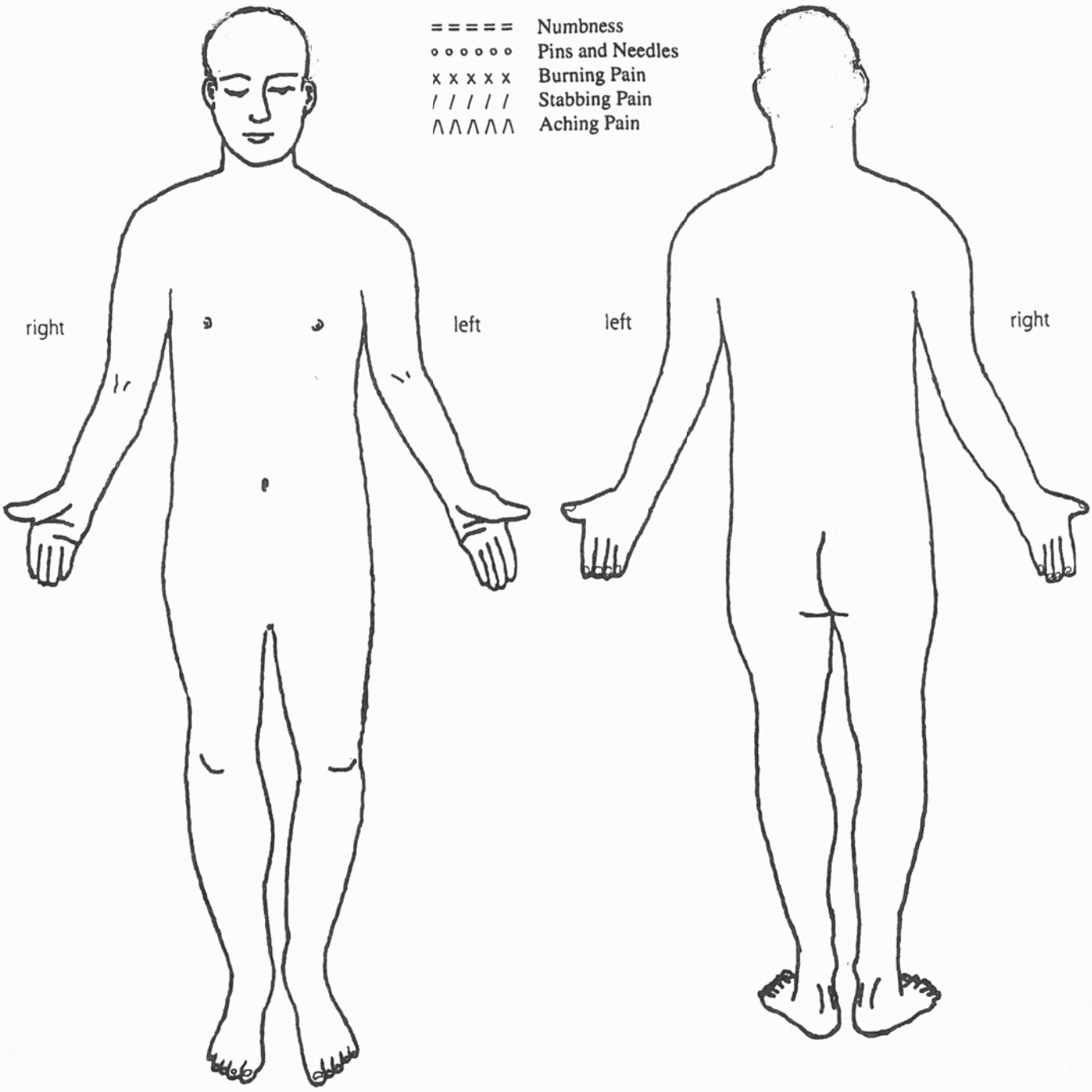
1. _____
2. _____
3. _____
4. _____

0-10 VAS Numeric Pain Distress Scale



***** Circle the number above that best represents your pain level.*****

Use the body diagram below to indicate the location of any of the sensations listed. Mark the areas on the drawings with the symbol that best describes the sensation that you feel.



Pain Management and Prescription Policy

Our practice will only provide pain medication to patients who require a surgical procedure. We do not provide long-term pain prescription services. The following outlines our pain medication prescription policy.

1. If it is felt surgery will be likely, patients may be prescribed pain medication during our initial evaluation and surgical preparation period. If surgery is not required, the patient will be referred back to his or her primary care physician to manage pain.
2. If surgery is necessary, pain medication will be prescribed prior to surgery if needed. Pain medication may also be prescribed for a predetermined period of time after the procedure is performed. During the recovery process, the amount of medication will be gradually reduced to help the patient avoid dependence.
3. All medication prescriptions will be addressed personally by the physician during the following hours:
   Monday – Thursday, between 8:00am and 3:00pm
   Friday, between 8:00am and 11:00am
   No Refills on the weekend
4. It may take 1 – 3 business days to refill your prescription. We must review your medical records, check for expiration dates, verify the number of refills and ensure refill eligibility.
5. Medications must be filled from only 1 pharmacy. Multiple pharmacy use is not acceptable. Each patient's profile is verified with pharmacies. This profile is filed in your permanent medical file. If you are receiving pain medication from another physician, we will not prescribe pain medications to you.
6. Medications will not be replaced if they are lost, stolen, or for any other reason. All medications are to be taken as prescribed. If a patient takes medication in excess of what is prescribed and runs out of the mediation early (prior to refill date), the refill will not be authorized early.
7. Physician will not refill prescriptions for patients not seen in the past 90 days.
8. If it is evident that these pain medications are being used inappropriately and against physician instructions, the proper authorities will be notified.

_____ _____

Signature of Patient or Responsible Party Date