

PATIENT INFORMATION				
PATIENT'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	PRIMARY CARE PHYSICIAN
MAIDEN NAME	EMAIL ADDRESS		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
STREET ADDRESS			APT. NO.	
CITY	STATE	ZIP	HOME PHONE	
SOCIAL SECURITY NUMBER	AGE	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	CELL PHONE	
EMPLOYER	OCCUPATION		WORK PHONE	
EMERGENCY CONTACT (NOT LIVING WITH YOU) / RELATION TO PATIENT			EMERGENCY CONTACT PHONE	
SPOUSE INFORMATION OR PARENT / RESPONSIBLE PARTY INFORMATION				
LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other _____	
STREET ADDRESS		APT. NO.	HOME PHONE	
CITY	STATE	ZIP	CELL PHONE	
SOCIAL SECURITY NO.			DATE OF BIRTH	
RESPONSIBLE PARTY EMPLOYER		OCCUPATION	RESPONSIBLE PARTY WORK PHONE/EXT.	
SECOND PARENT INFORMATION				
LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other _____	
STREET ADDRESS		APT. NO.	HOME PHONE	
CITY	STATE	ZIP	CELL PHONE	
SOCIAL SECURITY NO.			DATE OF BIRTH	
RESPONSIBLE PARTY EMPLOYER		OCCUPATION	RESPONSIBLE PARTY WORK PHONE/EXT.	
INSURANCE INFORMATION				
PRIMARY			COPAY	EFFECTIVE DATE
INSURANCE COMPANY ID (POLICY NO.)	GROUP NO.			
SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S SOCIAL SECURITY NO.	
SECONDARY			COPAY	EFFECTIVE DATE
INSURANCE COMPANY ID (POLICY NO.)	GROUP NO.			
SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S SOCIAL SECURITY NO.	

Insurance Payment Authorization and Release: I hereby authorize my insurance benefits to be paid directly to St. Louis Neurosurgery, LLC, and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information requested by my insurance company.

Authorized signature _____ **Date** _____

PLEASE BRING THIS FORM ALONG WITH YOUR INSURANCE CARD(S) AND APPLICABLE COPAY(S) TO YOUR APPOINTMENT.

THANK YOU!

St. Louis Neurosurgery, LLC

Armond Levy, MD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

I have received on this visit or a previous one, the Notice of Privacy Practices that explains how the facility may use my information. As explained in the Notice of Privacy Practices, the facility will only obtain my written authorization to release information about me if it is not permitted or required by law to disclose this information without authorization.

First Name	MI	Last Name	Date of Birth
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Signature of Patient / Parent or Legal Guardian	Date
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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request restriction on disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI may be made by alternative means such as: sending correspondence to the individual's office or cell phone, instead of the individual's home phone.

PLEASE CHECK ALL THAT APPLY

HOME TELEPHONE

- Leave Message with detailed information
- Leave Message with call back number only

CELL PHONE

- Leave Message with detailed information
- Leave Message with call back number only

WORK TELEPHONE

- Leave Message with detailed information
- Leave Message with call back number only

WRITTEN COMMUNICATION

- OK to Mail to home address
- OK to fax (when requested)
- OK to send message via Patient Portal

E-MAIL

- OK to send personal information via e-mail to:

_____ (preferred e-mail address)

I give consent to St. Louis Neurosurgery, LLC to release/discuss details of my medical care, including test results, medications, appointments, and other information with the persons listed below:

NAME	RELATIONSHIP	PHONE NUMBER

THIS DOCUMENT WILL BE A PART OF YOUR MEDICAL RECORD

St. Louis Neurosurgery, LLC

Comprehensive Health History / Medical Review of Systems

Welcome to St. Louis Neurosurgery! Your physician needs you to answer questions about your present and past medical history before you are examined. Although we ask you for a great deal of information, it will be reviewed in detail and it will be helpful in developing a plan or series of recommendations for your problem. Thank you in advance for your cooperation

Today's date: _____

Patient name: _____ DOB: _____

Referring Physician: _____ Physician's Phone Number: _____

Other Treating Physicians: _____

Occupation: _____ Current work status: _____

History of Present Illness

Reason for visit? _____

When did your problem begin? _____ Is it constant or does it "come & go"? _____

Were you involved in an injury? Explain. _____

Where is your problem? _____

What body parts are affected? _____

What circumstances, activities, or positions **worsen** the problem? _____

What circumstances, activities, or positions **lessen** your problem? _____

Do you have any other symptoms that may be related to your main problem (i.e. numbness, tingling, or weakness)? _____

What diagnostic tests have you had within the past year (x-rays, MRI, myelogram, CT scan, EEG)? _____

Treatment prior to today's visit (physical therapy, pain management, injections, home exercise)? _____

What medications have you tried? _____

Did any of the medications work? _____ Which ones? _____

Do any of the following conditions apply to you? Please check YES or NO.

General	Yes	No	Gastrointestinal	Yes	No	Psychiatric	Yes	No
fevers	<input type="checkbox"/>	<input type="checkbox"/>	constipation	<input type="checkbox"/>	<input type="checkbox"/>	depression	<input type="checkbox"/>	<input type="checkbox"/>
chills	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	anxiety	<input type="checkbox"/>	<input type="checkbox"/>
sweats	<input type="checkbox"/>	<input type="checkbox"/>	vomiting	<input type="checkbox"/>	<input type="checkbox"/>	memory loss	<input type="checkbox"/>	<input type="checkbox"/>
loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	nausea	<input type="checkbox"/>	<input type="checkbox"/>	suicidal ideas	<input type="checkbox"/>	<input type="checkbox"/>
fatigue	<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	paranoia	<input type="checkbox"/>	<input type="checkbox"/>
sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	mental disturbance	<input type="checkbox"/>	<input type="checkbox"/>
malaise	<input type="checkbox"/>	<input type="checkbox"/>	black tarry stool	<input type="checkbox"/>	<input type="checkbox"/>			
weight gain	<input type="checkbox"/>	<input type="checkbox"/>	yellow eyes or skin	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
weight loss	<input type="checkbox"/>	<input type="checkbox"/>				excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
speech delay	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	Yes	No	excessive eating	<input type="checkbox"/>	<input type="checkbox"/>
			urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>	excessive urination	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			incontinence	<input type="checkbox"/>	<input type="checkbox"/>	weight change	<input type="checkbox"/>	<input type="checkbox"/>
eye pain	<input type="checkbox"/>	<input type="checkbox"/>	blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
vision loss	<input type="checkbox"/>	<input type="checkbox"/>	pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>
excessive tears	<input type="checkbox"/>	<input type="checkbox"/>	pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>			
blurring	<input type="checkbox"/>	<input type="checkbox"/>	genital sores	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic/ Lymphatic		
double vision	<input type="checkbox"/>	<input type="checkbox"/>	vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	abnormal bruising	<input type="checkbox"/>	<input type="checkbox"/>
irritation	<input type="checkbox"/>	<input type="checkbox"/>	abnormal vag. bleeding	<input type="checkbox"/>	<input type="checkbox"/>	bleeding	<input type="checkbox"/>	<input type="checkbox"/>
discharge	<input type="checkbox"/>	<input type="checkbox"/>	loss of menstruation	<input type="checkbox"/>	<input type="checkbox"/>	enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
light hurts eyes	<input type="checkbox"/>	<input type="checkbox"/>	heavy menstruation	<input type="checkbox"/>	<input type="checkbox"/>			
						Allergic/Immunologic		
ENT			Musculoskeletal			hives	<input type="checkbox"/>	<input type="checkbox"/>
ear pain	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	hay fever	<input type="checkbox"/>	<input type="checkbox"/>
discharge	<input type="checkbox"/>	<input type="checkbox"/>	joint pain	<input type="checkbox"/>	<input type="checkbox"/>	persistent infections	<input type="checkbox"/>	<input type="checkbox"/>
tinnitus (ringing)	<input type="checkbox"/>	<input type="checkbox"/>	joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	HIV exposure	<input type="checkbox"/>	<input type="checkbox"/>
decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>	muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>			
nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	Health Screening (in past year)		
nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	stiffness	<input type="checkbox"/>	<input type="checkbox"/>	colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>
sore throat	<input type="checkbox"/>	<input type="checkbox"/>				mammogram	<input type="checkbox"/>	<input type="checkbox"/>
hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Skin			pap smear	<input type="checkbox"/>	<input type="checkbox"/>
trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	rash	<input type="checkbox"/>	<input type="checkbox"/>			
			itching	<input type="checkbox"/>	<input type="checkbox"/>	Other symptoms to report		
Cardiovascular			ulcers/growths	<input type="checkbox"/>	<input type="checkbox"/>	_____		
chest pain	<input type="checkbox"/>	<input type="checkbox"/>	excess scarring	<input type="checkbox"/>	<input type="checkbox"/>	_____		
palpitations	<input type="checkbox"/>	<input type="checkbox"/>	bleeding problem	<input type="checkbox"/>	<input type="checkbox"/>	_____		
fainting	<input type="checkbox"/>	<input type="checkbox"/>	dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____		
short breath-lying down	<input type="checkbox"/>	<input type="checkbox"/>	suspicious lesions	<input type="checkbox"/>	<input type="checkbox"/>	_____		
edema (swelling)	<input type="checkbox"/>	<input type="checkbox"/>				_____		
short breath-nighttime	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic			_____		
short breath -exertion	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>			
			fainting	<input type="checkbox"/>	<input type="checkbox"/>			
Respiratory			seizures	<input type="checkbox"/>	<input type="checkbox"/>			
wheezing	<input type="checkbox"/>	<input type="checkbox"/>	weakness	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	abnormal sensations	<input type="checkbox"/>	<input type="checkbox"/>	Former smoker?	<input type="checkbox"/>	<input type="checkbox"/>
excessive sputum	<input type="checkbox"/>	<input type="checkbox"/>	temporary paralysis	<input type="checkbox"/>	<input type="checkbox"/>			
coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Do you use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
			tremors	<input type="checkbox"/>	<input type="checkbox"/>	# of drinks per week? _____		

Please provide a copy of your current medications or list below
(include name, dose, frequency)

Preferred Pharmacy:

Please list any medication allergies and the type of reaction:

No Known Allergies

Past Medical History

Please list any chronic illnesses that you are currently being treated for.

Past Surgical History

Please list any surgeries or recent hospitalizations (include dates).

Family History

Relation	Age	Current Illness	<i>If applicable, Reason Of Death</i>	Age of Death
Father				
Mother				
Brother/Sister				
Child				

Height: _____

Weight: _____

Patient Name: _____ DOB: _____