St. Louis Neurosurgery, LLC

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	PRIMARY CARE PHYSICIAN

MAIDEN NAME	EMAIL ADDRESS	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W

STREET ADDRESS	APT. NO.

CITY	STATE	ZIP	HOME PHONE

SOCIAL SECURITY NUMBER	AGE	GENDER ☐ Male ☐ 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 ☐ Spouse ☐ Parent ☐ Legal guardian ☐ 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 ☐ Parent ☐ Legal guardian ☐ 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 INSURANCE COMPANY		COPAY	EFFECTIVE DATE

ID (POLICY NO.)	GROUP NO.	

SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH

SUBSCRIBER'S EMPLOYER	SUBSCRIBER'S SOCIAL SECURITY NO.

SECONDARY INSURANCE COMPANY		COPAY	EFFECTIVE DATE

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

Signature of Patient / Parent or Legal Guardian Date

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
fevers	☐	☐
chills	☐	☐
sweats	☐	☐
loss of appetite	☐	☐
fatigue	☐	☐
sleepiness	☐	☐
sleep problems	☐	☐
malaise	☐	☐
weight gain	☐	☐
weight loss	☐	☐
speech delay	☐	☐

Eyes		
eye pain	☐	☐
vision loss	☐	☐
excessive tears	☐	☐
blurring	☐	☐
double vision	☐	☐
irritation	☐	☐
discharge	☐	☐
light hurts eyes	☐	☐

ENT		
ear pain	☐	☐
discharge	☐	☐
tinnitus (ringing)	☐	☐
decreased hearing	☐	☐
nasal congestion	☐	☐
nosebleeds	☐	☐
sore throat	☐	☐
hoarseness	☐	☐
trouble swallowing	☐	☐

Cardiovascular		
chest pain	☐	☐
palpitations	☐	☐
fainting	☐	☐
short breath-lying down	☐	☐
edema (swelling)	☐	☐
short breath-nighttime	☐	☐
short breath -exertion	☐	☐

Respiratory		
wheezing	☐	☐
shortness of breath	☐	☐
excessive sputum	☐	☐
coughing blood	☐	☐

Gastrointestinal	Yes	No
constipation	☐	☐
diarrhea	☐	☐
vomiting	☐	☐
nausea	☐	☐
abdominal pain	☐	☐
change in bowel habits	☐	☐
blood in stool	☐	☐
black tarry stool	☐	☐
yellow eyes or skin	☐	☐

Genitourinary	Yes	No
urinary frequency	☐	☐
incontinence	☐	☐
blood in urine	☐	☐
pain with urination	☐	☐
pelvic pain	☐	☐
genital sores	☐	☐
vaginal discharge	☐	☐
abnormal vag. bleeding	☐	☐
loss of menstruation	☐	☐
heavy menstruation	☐	☐

Musculoskeletal		
back pain	☐	☐
joint pain	☐	☐
joint swelling	☐	☐
muscle cramps	☐	☐
muscle weakness	☐	☐
stiffness	☐	☐

Skin		
rash	☐	☐
itching	☐	☐
ulcers/growths	☐	☐
excess scarring	☐	☐
bleeding problem	☐	☐
dryness	☐	☐
suspicious lesions	☐	☐

Neurologic		
headaches	☐	☐
fainting	☐	☐
seizures	☐	☐
weakness	☐	☐
abnormal sensations	☐	☐
temporary paralysis	☐	☐
vertigo	☐	☐
tremors	☐	☐

Psychiatric	Yes	No
depression	☐	☐
anxiety	☐	☐
memory loss	☐	☐
suicidal ideas	☐	☐
hallucinations	☐	☐
paranoia	☐	☐
mental disturbance	☐	☐

Endocrine		
excessive thirst	☐	☐
excessive eating	☐	☐
excessive urination	☐	☐
weight change	☐	☐
cold intolerance	☐	☐
heat intolerance	☐	☐

Hematologic/ Lymphatic		
abnormal bruising	☐	☐
bleeding	☐	☐
enlarged lymph nodes	☐	☐

Allergic/Immunologic		
hives	☐	☐
hay fever	☐	☐
persistent infections	☐	☐
HIV exposure	☐	☐

Health Screening (in past year)		
colonoscopy	☐	☐
mammogram	☐	☐
pap smear	☐	☐

Other symptoms to report

_____

_____

_____

_____

_____

_____

	Yes	No
Do you smoke?	☐	☐
Former smoker?	☐	☐
Do you use alcohol?	☐	☐

# 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	*If applicable,* Reason Of Death	Age of Death
Father				
Mother				
Brother/Sister				
Child				

Height: _____ **Weight:** _____

Patient Name: _____ DOB: _____