Arlington Neurosurgical Spine Associates

WELCOME TO OUR OFFICE

Today's Date _____ Appointment Time _____ Account _____

Patient Name _____
First **Last** **Middle Initial**

Parent or Guardian Name (if applicable) _____Relationship_____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____Cell Phone _____Social Security # _____

Date of Birth _____ Age _____ Marital Status_____ Gender M ☐ F ☐

Spouse's Name _____ Date of Birth _____

Employer_____ Address _____ City/State_____ Zip _____

Emergency Contact_____ Relationship _____ Phone_____

Referring Physician_____ Phone _____ Fax _____

INSURANCE INFORMATION

INSURED EMPLOYER

Primary Insurance_____ Secondary Insurance _____

Are your symptoms a result of a work-related injury? ☐ YES ☐ NO

Employer Name _____ Address _____

Insurance Carrier_____ Claim# _____ Date of Injury _____

Name of Insurance Adjuster _____Phone _____

Treating Physician _____ Phone _____ Fax _____

We are a Texas Workers' Compensation (TWCC) provider and welcome you as a patient. Our staff is well-trained in working with the TWCC and we are pleased to be of assistance during your treatment. Failure to inform us of a work-related injury or filing for a workers' compensation after using your private insurance will result in you being held responsible for all fees. Failure to inform of a work-related injury will result in your private insurance refusing to pay a claim and demanding refund for any services provided to you. The workers' compensation carrier is not obligated to pay any fees for services rendered without approval of any appointed adjuster or insurance carrier.

Arlington Neurosurgical Spine Associates

HEALTH HISTORY

As a new patient to our practice please fill out the information below to the best of your ability.

Patient Name_____ DOB_____ Date_____

Chief Complaint _____

History of Present Illness:

Location (where is the pain located) _____

Severity (how severe pain scale 1-10) _____

Timing (does the pain occur at a specific time?) _____

Associated signs/symptoms _____

Duration (how long have you had this problem/symptom) _____

Modifying Factors (what makes symptoms worse/better) _____

Patient Medical History

Have you ever had the following (mark either "no" or "yes")

Measles	□ no □ yes	Anemia	□ no □ yes	Back Trouble	□ no □ yes
Mumps	□ no □ yes	Bladder Infections	□ no □ yes	High Blood Pressure	□ no □ yes
Chickenpox	□ no □ yes	Epilepsy	□ no □ yes	Low Blood Pressure	□ no □ yes
Whooping cough	□ no □ yes	Migraine Headaches	□ no □ yes	Hemorrhoids	□ no □ yes
Scarlet Fever	□ no □ yes	Tuberculosis	□ no □ yes	Asthma	□ no □ yes
Diphtheria	□ no □ yes	Diabetes	□ no □ yes	Hives/Eczema	□ no □ yes
Smallpox	□ no □ yes	Cancer (Type)	□ no □ yes	AIDS or HIV+	□ no □ yes
Pneumonia	□ no □ yes	Polio	□ no □ yes	Infectious Mono	□ no □ yes
Rheumatic Fever	□ no □ yes	Glaucoma	□ no □ yes	Bronchitis	□ no □ yes
Heart Disease	□ no □ yes	Prostate	□ no □ yes	Mitral Valve Prolapse	□ no □ yes
Arthritis	□ no □ yes	Blood or Plasma	□ no □ yes	Stroke	□ no □ yes
Venereal Disease	□ no □ yes	Transfusions	□ no □ yes	Hepatitis	□ no □ yes
Ulcer	□ no □ yes	Kidney Disease	□ no □ yes	Thyroid Disease	□ no □ yes
Bleeding Tendency	□ no □ yes	COVID-19	□ no □ yes	Elevated Cholesterol	□ no □ yes

IN THE BOX BELOW: List Other Diseases Not Shown or Provide Details Regarding a Specific Disease You Checked Yes to Above

HEALTH HISTORY (CONTINUED)

Previous Hospitalizations / Surgeries / Serious Illnesses:

1. Appendectomy	□ no □ yes	4. Hysterectomy	□ no □ yes
2. Tonsillectomy	□ no □ yes	5. Hernia	□ no □ yes
3. Gallbladder	□ no □ yes	6. Other	□ no □ yes

If you checked the 'other' box yes, please provide details:

_____

_____

Patient Social History:

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Use of Alcohol: □ Never □ Rarely □ Moderate □ Daily

Use of Tobacco □ Never □ Quit (what year) _____ Current (Packs/Day) _____

Use of Illicit Drugs □ Never Type/Frequency: _____

Family Medical History:

	Diseases	Deceased (Cause of Death)
Father (age) _____	_____	_____
Mother (age) _____	_____	_____
Sibling (age) _____	_____	_____
Sibling (age) _____	_____	_____

Medication Allergic

Penicillin	□ no □ yes	Morphine	□ no □ yes	Demerol	□ no □ yes
Novocain	□ no □ yes	Aspirin	□ no □ yes	Iodine	□ no □ yes
Merthiolate	□ no □ yes	Tetanus Antitoxin	□ no □ yes		

Other Drugs/Medication Allergic (not listed)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

HEALTH HISTORY (CONTINUED)

Review of Systems

Neurological

Frequent or recurring headaches	□ no	□ yes
Light headed or dizzy	□ no	□ yes
Convulsions or seizures	□ no	□ yes
Numbness or tingling sensations	□ no	□ yes
Tremors	□ no	□ yes
Paralysis	□ no	□ yes
Head Injury	□ no	□ yes

Musculoskeletal

Joint pain	□ no	□ yes
Joint stiffness or swelling	□ no	□ yes
Weakness of muscles or joints	□ no	□ yes
Back pain	□ no	□ yes
Cold extremities	□ no	□ yes
Difficulty in walking	□ no	□ yes
Muscle pain or cramps	□ no	□ yes

Constitutional Symptoms

Good general health lately	☐ no	☐ yes
Recent weight change	☐ no	☐ yes
Fever	☐ no	☐ yes
Fatigue	☐ no	☐ yes
Headaches	☐ no	☐ yes

Eyes

Eye disease or injury	☐ no	☐ yes
Wear glasses/contact lenses	☐ no	☐ yes
Blurred or double vision	☐ no	☐ yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing	☐ no	☐ yes
Earaches or drainage	☐ no	☐ yes
Chronic sinus problem /rhinitis	☐ no	☐ yes
Nose bleeds	☐ no	☐ yes
Mouth sores	☐ no	☐ yes
Bleeding gums	☐ no	☐ yes
Bad breath or bad taste	☐ no	☐ yes
Sore throat or voice change	☐ no	☐ yes
Swollen glands in neck	☐ no	☐ yes

Cardiovascular

Heart trouble	☐ no	☐ yes
Chest pain or angina pectoris	☐ no	☐ yes
Palpitation	☐ no	☐ yes
Shortness of breath with walking or lying flat	☐ no	☐ yes
Swelling of feet, ankles, hands	☐ no	☐ yes

Gastrointestinal

Loss of appetite	☐ no	☐ yes
Change in bowel movements	☐ no	☐ yes
Nausea or vomiting	☐ no	☐ yes
Frequent diarrhea	☐ no	☐ yes
Painful bowel movements or constipation	☐ no	☐ yes
Rectal bleeding or blood in stool	☐ no	☐ yes
Abdominal pain	☐ no	☐ yes

Genitourinary

Frequent urination	☐ no	☐ yes
Burning or painful urination	☐ no	☐ yes
Blood in urine	☐ no	☐ yes
Change in force of strain when urinating	☐ no	☐ yes
Incontinence or dribbling	☐ no	☐ yes
Kidney stones	☐ no	☐ yes
Sexual difficulty	☐ no	☐ yes
Male testicle pain	☐ no	☐ yes
Female pain with periods	☐ no	☐ yes
Female irregular periods	☐ no	☐ yes
Female vaginal discharge	☐ no	☐ yes
Female # of pregnancies		
Female # of miscarriages		
Female date of last pap smear _____		

Integumentary (skin, breast)

Rash or itching	☐ no	☐ yes
Change in skin color	☐ no	☐ yes
Change in hair or nails	☐ no	☐ yes
Varicose veins	☐ no	☐ yes
Breast pain	☐ no	☐ yes
Breast lump	☐ no	☐ yes
Breast discharge	☐ no	☐ yes

Psychiatric

Memory loss or confusion	☐ no	☐ yes
Nervousness	☐ no	☐ yes
Depression	☐ no	☐ yes
Insomnia	☐ no	☐ yes

Endocrine

Glandular or hormone problem	☐ no	☐ yes
Excessive thirst or urination	☐ no	☐ yes
Heat or cold intolerance	☐ no	☐ yes
Skin becoming dryer	☐ no	☐ yes
Change in hat or glove size	☐ no	☐ yes

Hematologic / Lymphatic

Slow to heal after cuts	☐ no	☐ yes
Bleeding or bruising tendency	☐ no	☐ yes
Anemia	☐ no	☐ yes
Phlebitis	☐ no	☐ yes
Past transfusion	☐ no	☐ yes
Enlarged glands	☐ no	☐ yes

Respiratory

Do you have a persistent cough or throat clearing not associated with a known illness (last more than 3 weeks?	☐ no	☐ yes
Spitting up blood	☐ no	☐ yes
Shortness of breath	☐ no	☐ yes
Wheezing	☐ no	☐ yes

HEALTH HISTORY (CONTINUED)

To the best of my knowledge, the questions on the Health History forms have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the staff to perform the necessary services I may need.

Signature of Patient / Guardian _____ **Date** _____

Doctor's Review of My Health History _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Doctor's Signature _____ **Date**_____

Arlington Neurosurgical Spine Associates

CURRENT MEDICATION

(Including Non-Prescription Medications)

Name _____ Date of Birth _____

Medication	Dosage	Frequency

Frederick Todd, II, M.D. 811 W. Interstate 20, Suite G10, Arlington, TX 76017 817-465-7764

CURRENT MEDICATION (CONTINUED)

(Including Non-Prescription Medications)

Name _____ Date of Birth _____

Medication	Dosage	Frequency

HEALTH INFORMATION

NAME _____ DOB _____

PRIMARY CARE PHYSICIAN

NAME _____ PHONE _____

PAIN MANAGEMENT PHYSICIAN

NAME _____ PHONE _____

CARDIOLOGIST (HEART)

NAME _____ PHONE _____

LAST SEEN _____ LAST EKG _____

LAST STRESS TEST: _____

PULMONOLOGIST (LUNG)

NAME _____ PHONE _____

LAST SEEN _____ LAST CHEST X-RAY _____

PHARMACY NAME _____ PHONE _____

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NOTICE OF PRIVACY PRACTICES / HIPAA OMINIBUS RULE 2013

PATIENT ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION AND RELEASE FORM. YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT AND AUTHORIZTION, BUT IN REFUSING WE MAY NOT BE ALLOWED TO PROCESS YOUR INSURANCE CLAIMS. THE UNDERSIGNED ACKNOWLEGES RECEIPT OF A COPY OF THE CURRENTLY EFFECTIVE NOTICE OF PRIVACY PROCTICES FOR THIS HEALTHCARE FACILITY. A COPY OF THIS SIGNED AND DATED DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

MY SIGNATURE WILL ALSO SERVE AS A "PHI" DOCUMENT RELEASE SHOULD I REQUEST TREATMENT RECORDS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

BY SIGNING THIS HIPAA PATIENT ACKNOWLEDGEMENT FORM, YOU ACKNOWLEDGE/AUTHORIZE THEIS OFFICE TO RECOMMEND PRODUCTS OR SERVICES TO PROMTE YOUR IMPROVED HEALTH. WE, UNDER THE CURRENT HIPAA OMNIBUS RULE, PROVIDE YOU THIS INFORMATION WITH YOUR KNOWLEDGE AND CONSENT.

PRINT NAME _____DOB _____ SIGNATURE _____

LEGAL REPRESENTATIVE_____ SIGNATURE _____

DESCRIPTION OF AUTHORITY_____

Please note any comments regarding ACKNOWLEDGEMENT / CONSENT _____

LIST ANY PARTIES YOU GIVE CONSENT TO ACCESS YOUR HEALTH INFORMATION

NAME _____

NAME _____

NAME_____

I AUTHORIZE INFORMATION ABOUT MY HEALTH TO BE COMMUNICATED VIA

HOME PHONE_____CELL/TEXT PHONE_____ EMAIL/MAIL_____

I AUTHORIZE OFFICE CONTACT TO CONFIRM APPOITMENT, TREATMENT, AND BILLING INFORMATION VIA

HOME PHONE_____ CELL/TEXT PHONE_____ EMAIL/MAIL_____

OFFICE USE ONLY

As the Privacy Officer, I attempted to obtain the patient/representative signature on this acknowledgement but didn't because of

☐ EMERGENCY TREATMENT ☐ UNABLE TO COMMUNICATE WITH PATIENT ☐ PATIENT UNABLE TO SIGN

PRIVACY OFFICER: _____ DATE: _____

SUMMARY NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT OF RECEIPT:

Under federal law Arlington Neurosurgical & Spine Associates P.A. (ANSA) is required to protect the privacy of certain parts of your protected health information (PHI) we hold in files. Upon you request, ANSA must give you a notice (referred to as our "Notice to Privacy regarding our use and disclosure of your PHI). You have legal right to review our Notice of Privacy Practices before you sign the consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice you may obtain a copy of the revised notices by accessing our website www.office@arlingtonneurosurgery.com) or contacting ANSA's Privacy Officer as listed below. You have a right to request us to restrict how we use and disclose your PHI for the purposes of treatment, payment or health care operations. We are no required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement with you. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI on reliance on you consent. By signing this form, you are granting consent to ANSA to use and disclose your PHI for the purposes of treatment, payment, and health care operations. I hereby acknowledge that I have been provided this Summary Notice of Privacy Practices and understand that I may at any time request to receive the full Notice of Privacy Practices from ANSA, Privacy Officer, 811 W. I-20 Suite G10, Arlington Texas 76017 (phone 817-465-7764).

FINANCIAL POLICY:

Our financial policy is an essential element of care and treatment. To give you the best care and service possible please read the following financial policy. Should you have any questions, feel free to discuss them with a member of our staff. Unless prior arrangements have been made, by either yourself or your insurance carrier, full payment is due at the time of service. The accompanying adult to a minor patient is responsible for payment. For your convenience, we accept all major credit cards (Visa, MasterCard, Discover, etc.) cash and checks. If you have Medicare/Medicaid coverage you will not be billed for services, until after Medicare has processed your claim (if secondary apply). You will receive a statement for our service after we receive payment from Medicare/Medicaid. We will bill those plans with which we have a prior agreement with and will collect required copayments at the time of service. If your health plan determines a service to be "not covered" you will be responsible for the complete charge or remaining balance. Payment is due upon receipt of that statement. If you are covered by and insurance plan with which we DO NOT have an agreement, we will prepare and send a claim to your insurer which in return will send the payment directly to you, therefore, charges for your care and treatment will be due at the time of service. Our office will also bill your health plan for all services we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office. Copayments are due at the time of service. As stated in our contract with your insurance company, we are not permitted to bill you for these services. Failure to pay these copayments may result in your account being turned over to an outside collection agency. This action will not compromise your medical care. Authorization from insurance companies may be required for office visits in order to receive full benefit coverage. If you are not sure authorization is required for your plan. Please contact your insurance company, employer, or primary care physician. If required, an authorization must be received by our office prior to visit. Failure to provide Arlington Neurosurgical & Spine Associates and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice.

PAIN MEDICATION AND PRESCRIPTION POLICY:

Arlington Neurosurgical Spine & Associates can only provide pain medication for patients who required a surgical procedure to relieve pain prior to surgery and to assist with recovery from surgery. Our practice does not provide long-term pain management services. 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 or make additional referrals. 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 this recovery process, the amount of medication will be gradually reduced to help the patient avoid dependency of the drug. Pain medication is to be taken as proscribed. Patients are not to increase medications, or this can lead to the termination of the physical-patient relationship. So that we may carefully review all patient records, we require a 24-hour advanced notice for prescription refills, medical records, prescriptions cannot be filled in the evening, on weekends or holidays. If long-term management is required, the patient will be referred to a pain management clinic or to his or her primary care physician. I have read and understand the above stated pain medication and prescription policy for Arlington Neurosurgical & Spine Associates.

☐ **I ACCEPT** ☐ **I DECLINE**

Signature Patient/Responsible Party_____ Date_____

Witness Signature _____Date _____