Comprehensive
Neurosurgical
Consultants

PATIENT DEMOGRAPHIC INFORMATION

Name:			**DOB:**	**Sex: M [ ] F [ ]**
Address:			**Home Phone:**	
			Cell Phone:	
City:	**State:**	**Zip:**	**Work Phone:**	
Pharmacy Name:			**Marital Status:** [ ] Married [ ] Single	
Pharmacy Phone:			[ ] Divorced [ ] Widow	
Email:			**Preferred Language:**	
Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino				
Race: [ ] Asian [ ] American Indian or Alaska Native [ ] Black or African American				
[ ] White [ ] Native Hawaiian or Other Pacific Islander [ ] Patient Declined				
Employment Information: [ ] Employed [ ] Unemployed [ ] Retired [ ] Other				
Employer's Name:			**Occupation:**	
Referring Physician:			**Primary Physician:**	
Emergency Contacts				
Name:	Relationship:		Phone:	
Name:	Relationship:		Phone:	
Responsible Party (if patient is under 18)				
Name:			**Home Phone:**	
DOB:	**Address:**			
Employer:				
Primary Insurance:			**Secondary Insurance:**	
Insurance Name:			**Insurance Name:**	
ID#:			**ID#:**	
Group#:			**Group#:**	
Subscriber Name:			**Subscriber Name:**	
Relationship to Patient:			**Relationship to Patient:**	
Subscriber DOB:			**Subscriber DOB:**	
Work Related Injury: [ ] YES (complete section below) **[ ] NO**				
Insurance Name:			**Insurance Phone:**	
Claim Number:			**Date of Injury:**	
Employer at time of injury:				

Medical History Form

To help us better evaluate your condition, please complete the following form. If you have any questions, we will be glad to help you. Thank you.

Name: _____ DOB:_____

Please List Current Medications and Dose

_____ _____

_____ _____

_____ _____

_____ _____

Please List Medical Allergies and Corresponding Reactions

_____ _____

_____ _____

____I have no known allergies.

Past Medical History
(Please circle conditions that you have a history of)

Alcoholism	Blood Transfusions	Heart Pain /Angina	Lung Cancer	Severe Allergy
Anemia	Bowel Disease	Hepatitis A	Lung / Respiratory Disease	Skin Cancer
Anesthetic Complications	Breast Cancer	Hepatitis B	Mental Illness	Stroke / CVA Brain
Anxiety	Cervical Cancer	Hepatitis C	Migraines	Suicide Attempt
Arthritis	Colon/Rectal Cancer	High Blood Pressure	Osteoporosis	Tyroid Problems
Asthma	Depression	High Cholesterol	Prostate Cancer	Ulcer
Autoimmune Problems	Diabetes	HIV	Reflux / Gerd	Other Disease or Cancer
Birth Defects	Development Disorder	Kidney / Bladder Disease	Seizures / Convulsions	NONE of the Above
Bleeding Disease	Heart Attack	Liver Cancer	Sexually Transmitted Disease	
Blood Clots	Heart Disease	Liver Disease		

Past Surgical History

Type of Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Family History
(Please circle conditions your family has a history of)

Family History Unknown	Bleeding Disorders	High Blood Pressure	Seizures / Convulsions
Alcoholism	Breast Cancer	High Cholesterol	Severe Allergy / Hives
Anemia	Colon /Rectal Cancer	Kidney / Bladder Disease	Stroke / CVA of Brain
Anesthetic Problems	Depression	Lung / Respiratory Disease	Thyroid Problems
Arthritis	Diabetes	Migraines	Other Disease or Cancer
Asthma	Heart Disease	Osteoporosis	None of the Above

Has your mother, grandmother or a sister developed heart disease before the age of 65? YES NO

Has your father, grandfather, or a brother developed heart disease before the age of 55? YES NO

Name: _____ DOB: _____

RISK FACTORS:

Tobacco Use

Are you exposed to passive (second hand) smoke? YES NO

How would you describe your cigarette smoking status? Current Previous Never

(If you marked Never, skip to next section)

At what age did you begin smoking? _____ If you quit smoking, at what age did you quit? _____

How many cigarettes do you currently smoke or did you previously smoke per day? _____

How many cigars or pipes do you smoke per week? _____

How many cans of smokeless/chewing tobacco do you use per week? _____

Drug Use

Do you use recreational drugs? YES Type: _____ NO

HIV High Risk Behavior

Do you have a history of?
IV Drug Use / More than one sexual partner / Unprotected Sexual Contact YES NO Prefer to Discuss with Physician

Alcohol Use

How often do you drink alcohol? Never or Number of drinks per week:_____

(If you marked Never, skip to next section)

What type of alcohol do you drink? Beer Wine Liquor

How many drinks do you have per occasion? _____

How often do you have more than five drinks per occasion? Never Rarely Occasionally Frequently

Habits

Do you drink caffeine-containing products? Coffee Tea Soft Drinks N/A

How many per day? _____

Do you exercise? Never Occasionally Frequently Times per Week: 1-2 3-4 4-6 7+

Types of Exercise Bicycling Running Swimming Walking Aerobics Other

How often do you wear a seatbelt? % of time used: 100% 75% 50% 25%

What is your sun exposure? Rare Occasional Frequent

Preventative Care (female only):

Date of last mammogram (approximate date ok) :_____
Date of last pap smear (approximate date ok): _____

Current Height: _____inches **Current Weight: _____pounds**

Name: _____ **DOB:** _____

STOP-Bang Scoring Tool

To detect suspected Obstructive Sleep Apnea (OSA)

Have you ever been diagnosed with OSA? YES NO

a. If YES, do you have a CPAP machine? YES NO
b. If YES, are you currently using the CPAP machine? YES NO

If you answered NO to the above question, please answer the questions below.

Snore	**Do you snore loudly?** *(Louder than talking or loud enough to be heard through closed doors)*	**YES**	**NO**
Tired	**Do you often feel tired, fatigued or sleepy during daytime?**	**YES**	**NO**
Observed	**Has anyone observed you stop breathing during your sleep?**	**YES**	**NO**
Pressure	**Do you have, or are you being treated for high blood pressure?**	**YES**	**NO**
BMI	**Is your BMI more than 35?** *(We can calculate Height_____ Weight_____)*	**YES**	**NO**
Age	**Are you over 50 years old?**	**YES**	**NO**
Neck	**Is your neck circumference greater than 17"(male) or 16"(female)?** *(We can measure)*	**YES**	**NO**
Gender	**Are you a male?**	**YES**	**NO**

If you answered YES to 3 more questions, you are at high risk of having obstructive sleep apnea (OSA). We will talk to you more during the visit about OSA increased risk when having surgery and when taking prescription narcotics. In addition, we'll send a letter to your PCP recommending further evaluation and consideration of sleep study.

PAIN CHART

Patient Name: _____ DOB: _____

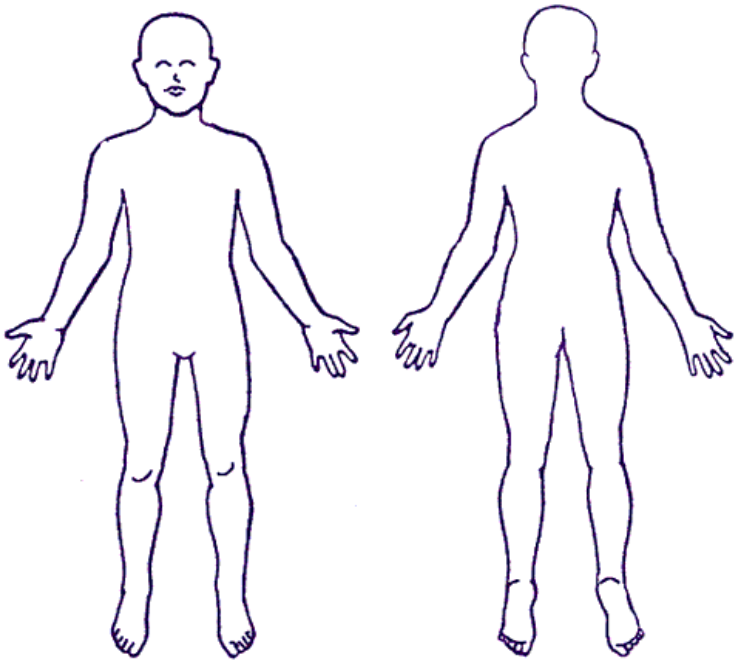
Current Problem Pain Diagram

Rate your neck or back pain on a scale from 1-10 (Best) 1 2 3 4 5 6 7 8 9 10 (Worst)

Rate your arm or leg pain on a scale from 1-10 (Best) 1 2 3 4 5 6 7 8 9 10 (Worst)

Mark the area of your body where you feel painful sensations. Use the appropriate symbols:

Numbness, pins and needles, burning - 00
Aching, grabbing, cramping - XX
Shocking, stabbing, electric - \\



R **L** **L** **R**

When did symptoms start? _____

Have you tried physical therapy? YES NO If YES where: _____

Duration: _____ Date Started:_____

Have you tried non-steroidal anti-inflammatory (NSAID) medications (Ibuprofen, Advil, Aleve, Ketoprofen, Motrin, Naproxen?) – circle ones you took

If YES: Duration: _____

Review of Systems

Patient Name: _____ DOB: _____

General: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Fevers
- ☐ Appetite loss
- ☐ Fatigue (always tired)
- ☐ Chills
- ☐ Weight loss
- ☐ Sweats
- ☐ "feeling sick"
- ☐ None

Eyes: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Vision loss – 1 eye
- ☐ Vision loss – both eyes
- ☐ "halos" around lights
- ☐ Double vision
- ☐ Blurring
- ☐ Discharge
- ☐ Eye irritation
- ☐ Eye pain
- ☐ Light sensitivity
- ☐ None

Ears/Nose/Throat: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Ringing in the ears
- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Ear discharge
- ☐ Nasal congestion
- ☐ Hoarseness
- ☐ Earache
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ None

Cardiovascular: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Difficulty breathing at night
- ☐ Racing/skipping heart beats
- ☐ Shortness of breath with exertion
- ☐ Difficulty breathing while lying down
- ☐ Bluish discoloration of lips or nails
- ☐ Near fainting
- ☐ Fatigue
- ☐ Palpitations
- ☐ Fainting
- ☐ Weight gain
- ☐ Chest pain or discomfort
- ☐ Lightheadedness
- ☐ Swelling of hands or feet
- ☐ Leg cramps with exertion
- ☐ None

Respiratory: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Sleep disturbances due to breathing
- ☐ Coughing up blood
- ☐ Excessive sputum
- ☐ Cough
- ☐ Chest discomfort
- ☐ Excessive snoring
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ None

Gastrointestinal: (Mark all that apply; If no symptoms, please mark "none")

- ☐ Excessive appetite
- ☐ Vomiting blood
- ☐ Yellowing skin color
- ☐ Abdominal bloating
- ☐ Change in bowel habits
- ☐ Bloody stools
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Indigestion
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Dark tarry stools
- ☐ None

Genitourinary: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Foul urinary discharge
- ☐ Inability to empty bladder
- ☐ Trouble starting urinary stream
- ☐ Inability to control bladder
- ☐ Excessively heavy periods
- ☐ Other abnormal vaginal bleeding
- ☐ Blood in urine
- ☐ Urinary urgency
- ☐ Painful urination
- ☐ Genital sores
- ☐ Missed periods
- ☐ Pelvic pain
- ☐ Urinary frequency
- ☐ Kidney pain
- ☐ Night time urination
- ☐ Lack of sexual drive
- ☐ Unusual urinary color
- ☐ None

Musculoskeletal: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Muscle cramps
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Presence of joint fluid
- ☐ Back pain
- ☐ Stiffness
- ☐ Muscle weakness
- ☐ Arthritis
- ☐ Gout
- ☐ Loss of strength
- ☐ Muscle aches
- ☐ None

Skin: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Excessive perspiration
- ☐ Dryness
- ☐ Itching
- ☐ Changes in nail beds
- ☐ Skin cancer
- ☐ Rash
- ☐ Unusual hair distribution
- ☐ Flushing
- ☐ None
- ☐ Changes in color of skin
- ☐ Suspicious lesions
- ☐ Night sweats
- ☐ Poor wound healing

Neurologic: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Difficulty with concentration
- ☐ Poor balance
- ☐ Headaches
- ☐ Disturbances in coordination
- ☐ Numbness
- ☐ Inability to speak
- ☐ Falling down
- ☐ Tingling
- ☐ Brief paralysis
- ☐ Visual disturbances
- ☐ Seizures
- ☐ Weakness
- ☐ Sensation of room spinning
- ☐ Tremors
- ☐ Fainting
- ☐ Excessive daytime sleeping
- ☐ Memory loss
- ☐ None

Psychiatric: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Sense of great danger
- ☐ Anxiety
- ☐ Thoughts of violence
- ☐ Mental problems
- ☐ Depression
- ☐ None
- ☐ Frightening visions or sounds
- ☐ Thoughts of suicide

Endocrine: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ none
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Weight change

Heme/Lymphatic: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Enlarged lymph nodes
- ☐ Bleeding
- ☐ Skin discoloration
- ☐ Abnormal bruising
- ☐ Fevers
- ☐ None

Allergic/Immunologic: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Persistent infections
- ☐ HIV exposure
- ☐ Hives or rash
- ☐ Seasonal allergies
- ☐ None

Financial Policy

Patient Name:_____ DOB:_____

Comprehensive Neurosurgical Consultants is committed to providing the highest level of quality care and customer service to our patients. In an effort to provide clear communication with our patients, we have outlined our financial policies below. Please speak to your Physician or the Practice Administrator if you have any questions about this document.

Financial Responsibility:
It is the patient and/or their guardian's responsibility to meet the financial obligations for all healthcare services received. As we accept a large variety of different insurance plans, it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. In addition, insurance companies will not guarantee payment to us. Your insurance benefits are a contract between you and the insurance company. While our office will do everything within our means to obtain necessary authorizations and communicate with your insurance company, it is still your responsibility to ensure that all services rendered are paid in full.
Co-payments and deductibles are a contract responsibility between the patient and their insurance company. These amounts are non-negotiable.

Patients Without Insurance Coverage:
Payment at the time of service is required for all self-pay patients. Before being seen, we require a deposit of $250.00 for all new patient office consults and 50% of total estimated costs for all surgical procedures.

Participating Insurances:
We participate with a variety of insurance plans. It is your responsibility to:
- Verify with your insurance company that we are a contracted provider
- Bring your insurance card and picture ID to every visit
- Be prepared to pay your co-pay, if applicable, at the time of your visit
- Provide any referral required by your insurance prior to or at the time of your visit.

Appointments:
As a courtesy, 48 hours notice is expected if you need to cancel or reschedule your appointment. Missed appointments may be assessed a fee.

Surgical Costs:
Your insurance company will be contacted to verify benefits and eligibility prior to surgery. Pre-payment of deductibles may be required. You will be provided with a surgical financial policy in the event you are scheduled for surgery.

Payment Plans:
In special situations, we are able to provide payment plans when necessary and appropriate. These arrangements can be made with our billing office. Please notify your physician's staff, if you require this option. All payment plan agreements will be submitted in writing. Should you be unable to keep to the terms of the agreement, your account will be sent to collections.

Collection Accounts:
If your account is sent to collections, you will need to contact our collection agency to make payment arrangements. You will be required to pre-pay for future office visits after having a bad debt account with us, even if you have paid the amount owing with the collection agency.

Form Fees

Because of the large volume of FMLA/Legal forms that come to our office, a $25.00 charge is due at the time the form is presented for completion. Please turn in forms as soon as possible as it may take up to 10 days for completion of your forms.

Please note this office does NOT accept Motor Vehicle or Workers Compensation insurance. If your injury is related to an accident or is work-related, we are not able to bill your third party insurance. We will send all bills to you personally and you will be responsible for submitting these to your third party insurance company for reimbursement. You will be financially responsible for all outstanding costs.

I have read and understand this financial policy.

_____ _____

Patient's Signature or Legal Guardian **Date**

Relationship to Patient:_____

Patient Consent for Use and Disclosure of Health Information

Patient Name:_____ DOB: _____

I hereby give my consent for Comprehensive Neurosurgical Consultants to use and disclose protected health information about me to carry out treatment, payment, and health care operations.
(The Notice of Privacy Practices provided by Comprehensive Neurosurgical Consultants describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Comprehensive Neurosurgical Consultants reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Comprehensive Neurosurgical Consultants 9155 SW Barnes Rd, Ste 210 Portland OR 97225.

With this consent, Comprehensive Neurosurgical Consultants may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Comprehensive Neurosurgical Consultants may mail to my home or other alternative location any items that assist the practice in carrying out health care operations, such as appointment reminder cards and patient statements.

With this consent, Comprehensive Neurosurgical Consultants may e-mail to my home or other alternative location any items that assist in carrying out health care operations, such as appointment reminders and patient statements.

I authorize the following individuals to have access to my protected health information:

_____

Name Phone Number Relationship

_____

Name Phone Number Relationship

I have the right to request that Comprehensive Neurosurgical Consultants restrict how it uses or discloses my personal health information to carry out health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Comprehensive Neurosurgical Consultants to use and disclose my personal health information to carry out health care operations.

I authorize having my photograph taken for my Electronic Medical Record.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Comprehensive Neurosurgical Consultants may decline to provide treatment to me.

Insurance Authorization and Assignment

I attest that the insurance information I have given to the office is correct and true to the best of my knowledge. I hereby assign benefits to be paid to the doctor, and authorize Comprehensive Neurosurgical Consultants to furnish information regarding my illness to my insurance carrier.

_____ _____

Patient's Signature or Legal Guardian **Date**

Relationship to Patient:_____