Health ONE® Colorado Neurosurgery Associates
Physician Care℠

**PATIENT INFORMATION** (Please Print)

Patient's Name (Last) _____ First) _____ (MI) ___ Previous Name _____

Address Line 1 _____

City, State _____ ZIP_____ Pharmacy_____ Pharmacy Phone _____

Home Phone _____ Cell No. _____ Work Phone _____Ext. _____

E-Mail Address:_____Primary Care Provider (PCP) _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

How did you hear about us? _____

**RESPONSIBLE PARTY INFORMATION – ONLY IF PATIENT IS A MINOR (Or Power of Attorney relationship)**

Responsible Party (**If minor**) ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer_____ Employer Phone Number_____

**PRIMARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ Date of Birth MM _____/DD _____/YYYY _____

**SECONDARY INSURANCE INFORMATION (If Medicare, please provide reason)** (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____Date of Birth MM _____/DD _____/YYYY___

Medicare Secondary reason ☐ Working Aged Beneficiary/Spouse ☐ Disabled Beneficiary under age ☐ Other liability

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

***Patient (or Responsable Party) Signature***_____ ***Date***_____

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# Patient History

Patient Name: _____

Date of Birth _____/_____/_____ Age _____ Height _____ Weight_____

Race _____ Preferred Language_____ Ethnicity(circle one): Non-hispanic Hispanic/Latino

Circle one: Right-handed Left-handed Ambidextrous

Present Complaint or Problem: _____
Duration of Present Complaint or Problem: _____

## Treatment for this problem

| | Date | Relief? | | Date | Relief? |
|---|---|---|---|---|---|
| Physical Therapy | _____ | _____ | Chiropractor | _____ | _____ |
| Brace | _____ | _____ | TENS Unit | _____ | _____ |
| Acupuncture | _____ | _____ | Exercises | _____ | _____ |
| Massage | _____ | _____ | Injections | _____ | _____ |
| Physiatry/Rehab MD | _____ | _____ | Other | | |

## *PAST MEDICAL HISTORY*

Please ✓ box next to any condition with which YOU have been diagnosed, or list other:

| Medical | Medical | Neurological | Pertinent to Surgery |
|---|---|---|---|
| □ None | □ GERD / Reflux | □ Aneurysm | □ Anticoagulation |
| □ Anemia | □ Glaucoma | □ CVA/Stroke | □ Bleeding Disorder |
| □ Anxiety | □ Heart Disease | □ Brain Tumor | □ Chronic Pain |
| □ Asthma | □ Hepatitis | □ Hydrocephalus | □ Clotting Disorder |
| □ Atrial Fibrillation | □ HIV | □ Migraines | □ DVT |
| □ Autoimmune Disorder | □ High cholesterol/lipids | □ Multiple Sclerosis | □ Hemophilia |
| □ Enlarged Prostate | □ High Blood Pressure | □ Parkinson's Disease | □ Narcotic use > 6 mo |
| □ Cancer – Breast | □ Irritable bowel disease | □ Peripheral Neuropathy | □ Anesthesia Problems |
| □ Cancer – Lung | □ Myocardial infarction | □ Pituitary Tumor | □ Pulmonary Embolism |
| □ Cancer – Renal | □ Nasal Allergies | □ Seizure Disorder | □ Other: |
| □ Cancer – Colon | □ Osteoarthritis | □ Spinal Cord Injury | |
| □ Cancer – Prostate | □ Osteoporosis | □ TIA | |
| □ COPD | □ Renal Disease | □ Traumatic Brain Injury | |
| □ Depression | □ Rheumatoid Arthritis | □ Trigeminal Neuralgia | |
| □ Diabetes – Type I | □ Thyroid Disease | □ Other: | |
| □ Diabetes – Type 2 | □ Vision Loss | | |
| □ Fibromyalgia | □ Other: | | |

Have you ever been *DIAGNOSED* with any other major health problem not listed above? No Yes
If yes, please list diagnosis and year the diagnosis was made:

_____ _____
_____ _____
_____ _____

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*SURGERIES :*

Have you ever had surgery? No Yes

If yes, list name / type of surgeries and when they were done.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

*ALLERGIES:*

Are you allergic to ANY medication, food, or non-medications (such as pollen, etc.)? No Yes

If yes, please list below. Name of Medication / Food / Agent Type of Reaction, i.e. rash, breathing problems, swelling, etc

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

*PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (PLEASE PRINT NEATLY)* None

If you need more space for your medications, please provide a list on a separate sheet

| Name, dose (i.e., 2 mg, 60 mg, etc) | Frequency (i.e. twice daily, at bedtime) | Problem being treated Prescribing Doctor |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*FAMILY HISTORY* Please place ✓ in box next to any condition with which a member of your immediate family (i.e., mother, father, brother, sister) has been diagnosed: Unknown Adopted None

| | | | |
|---|---|---|---|
| □ FH Alcoholism | □ FH Breast Cancer | □ FH High Blood Pressure | □ FH Ovarian Cancer |
| □ FH Anemia | □ FH Cervical Cancer | □ FH High Cholesterol | □ FH Psychiatric Care |
| □ FH Angina | □ FH Colon Cancer | □ FH Kidney Disease | □ FH Respiratory Disease |
| □ FH Arthritis | □ FH Depression | □ FH Liver Disease | □ FH Seizures |
| □ FH Asthma | □ FH Diabetes | □ FH Lung Cancer | □ FH Severe Allergies |
| □ FH Birth Defects | □ FH Growth Problems | □ FH Skin Cancer | □ FH Stroke |
| □ FH Blood Clots | □ FH Headaches | □ FH Osteoporosis | □ FH Thyroid Disease |
| □ FH Bowel Disease | □ FH Heart Disease | □ FH Other Cancer | □ FH Uterine Cancer |

*SOCIAL HISTORY*

Do you currently smoke / use tobacco in any form? No Yes
If yes, do you smoke or chew tobacco: _____
If yes, have you tried a smoking cessation or counseling program_____

Do you have a history of smoking/tobacco use? ... No Yes
If yes, when did you quit? _____

Do you currently drink alcohol? ..... No Yes
If yes, please list how much a week:_____

Do you have history of alcohol abuse? ..... No Yes
If yes, when did you quit? _____

Do you currently use any recreational drugs: ..... No Yes
If yes, what type and how often: _____

Employment Status: Employed Unemployed Retired Disabled Self-employed

What is or was your occupation? _____

Marital Status: Married Partner Single Divorced Widowed

This Information is true and complete to the best of my knowledge.

**Signature of Patient or Legal Guardian**_____ **Date**___/___/___

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**Name: _____** **Today's Date: _____**

## REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or patients we haven't seen for a while, we need to update our records as to your general medical health. In each area, please circle "No Problems" if you are not having any difficulties. If, you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed.

**GENERAL HEALTH** No Problems Lack of energy, unexplained weight gain or loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other:_____

**EARS, NOSE, MOUTH, AND THROAT** No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other:
_____

**C-V (HEART AND BLOOD VESSELS)** No Problems Irregular heartbeat, racing heart, chest pain, swelling in feet or legs, pain in legs with walking. Other: _____

**RESPIRATORY (LUNGS)** No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray
Other:_____

**GI (STOMACH AND INTESTINES)** No Problem Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stool, unexplained change in bowel habits, incontinence. Other:
_____

**GU (KIDNEY AND BLADDER)** No Problem Painful urination, frequent urination, urgency, prostate problems, bladder problems, incontinence. Other: _____

**MS (MUSCLES, BONES, JOINTS)** No problem Joint pain, aching muscles, swelling or joints, joint deformities, neck pain, low back pain. Other: _____

**INTEG. (SKIN, HAIR, BREASTS)** No Problem Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

**NEUROLOGIC (BRAIN AND NERVES)** No problem Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other:
_____

**PSYCHIATRIC (MOOD AND THINKING)** No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

**ENDOCRINOLOGIC (GLANDS)** No Problem Intolerance to heat/cold, menstrual irregularities, frequent hunger/thirst/urination, changes in sex drive. Other: _____

**HEMATOLOGIC (BLOOD/LYMPH)** No Problem Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

**ALLERGIC/IMMUNOLOGIC** No Problem Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

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I, the undersigned, authorize Colorado Neurosurgery Associates to leave (circle one)

DETAILED OR GENERAL

Voicemail messages regarding future appointments, test results, and personal information on the number I specify:

Phone number: (_____)_____

**Signature:** _____ **Date:** _____

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# General Consent for Care and Treatment Consent

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

| | |
|---|---|
| **Signature of Patient or Personal Representative** | **Date** |
| **Printed** Name of Patient or Personal Representative | **Relationship to Patient** |
| **Printed** Name of Witness | Employee Job Title |
| **Signature of Witness** | **Date** |

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**Financial Policy:**

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions please discuss them with our billing staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made in advance by yourself or your health coverage carrier, **full payment for office services are due at the time of service**.

For you convenience we will accept VISA, MasterCard, Discover, and American Express, as well as cash, check or money order.

**About Health Insurance:**

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.

**About Participating Health Plans:**

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-payment **at the time of service**.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

For all service rendered to minor patients we will look to the adult accompanying the patient and parent or guardian with custody for payment.

It is your responsibility to verify that this office participated with your insurance. If we do not participate with your insurance, you will likely be responsible for all charges out of pocket.

**By signing below, I acknowledge that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.**

_____ _____

**Signature of Patient or Personal Representative** **Date**

_____ _____

**Printed Name if signed on behalf of patient** **Relationship to Patient**