MIDWEST NEUROSURGERY & SPINE
Adult & Pediatric SPECIALISTS

COMPLETE ALL FIVE PAGES
BLACK INK ONLY

Checked-in: _____ *Updated*: _____

First Name: _____ **MI**: _____ **Last**: _____

SSN: _____-_____-_____ **Age**: _____ **Race**: _____

Sex: _____ **Date of Birth**: _____-_____-_____ **Marital Status**: _____

Home Address: _____
(Street) (City) (State) (Zip)

Address 2 *(if applicable)*: _____
(PO BOX/ APT)

E-mail: _____ **Home Phone**: ( )_____

Work: ( )_____ **Cell Phone**: ( )_____

Employment Status: Yes / No / Retired **Employer**: _____

Primary Pharmacy: _____
(*i.e. Walgreens 90th & Dodge*)

Requesting/Referring Physician: _____

Family Physician: _____

Emergency Contact

Nearest relative or friend *not living with you* in case of emergency:

Full Name: _____ Relationship:_____

Phone #: ( )_____

Health Insurance Information

Primary Insurance Carrier Name: _____ Co-pay: _____

Policy (ID) #: _____ Group #: _____

Primary Card Holder Name: _____

Relationship to Patient: _____ SSN: _____-_____-_____ DOB: _____

Employer: _____ Work #: ( )_____

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Patient Name: _____

Secondary Insurance Carrier Name: _____ Co-pay: _____

Policy (ID) #: _____ Group #: _____

Primary Card Holder Name: _____

Relationship to Patient: _____ SSN: _____-_____-_____ DOB: _____

Employer: _____ Work #: ( )_____

Auto Insurance *(if motor vehicle accident):* _____

Name of Policy Holder: _____ Claim #: _____

Address of Insurance Company: _____ City: _____ State: _____ Zip: _____

Phone #: ( )_____ Accident Date: _____

Name of person handling claim: _____

Work Comp Information *(if applicable):*

Work Comp Carrier: _____

Claim #: _____ Claims Adjustor: _____ Date of Injury: __/__/__

Address: _____ City: _____ State: _____ Zip: _____

Phone #: ( )_____ Ext. #: _____ Fax #: ( )_____

Case Manager: _____ Case Manager Phone #: ( )_____

Legal (if applicable):

If you have an attorney or legal action current or pending for which you are seeking legal consultation:

Attorney Name: _____ Phone #: ( )_____

SELF PAY: *****$250 PREPAYMENT REQUIRED PRIOR TO YOUR CLINIC VISIT*****

Please read & sign our Financial Policy & meet with the Financial Counselor in our office.

Patient Name: _____ Date of Birth:_____

Height: _____ Weight: _____ Current Age: _____

Reason for today's visit: _____

Current problem is the result of: (***Check all that apply***)

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other: _____

Date of Accident (*if applicable*): _____

Surgeries/Hospitalizations	Year	Complications

Problems with anesthesia? ☐ No ☐ Yes: _____

Taking blood thinners? ☐ No ☐ Yes: _____

Allergy to Latex? ☐ No ☐ Yes: _____

Malignant Hyperthermia? ☐ No ☐ Yes

Current Medication(s)	Dose	Frequency

Allergies to Medications ☐ **None**

Medication	Reaction

Patient Name: _____

Do you have any of the following?

Hepatitis	Heart Disease	Asthma	High Blood Pressure
High Cholesterol	Stroke/CVA	Lung Disease	Thyroid Disease
Liver Disease	Kidney Disease	Blood Clot	Pulmonary Embolism
Ulcer	Diabetes	Blood transfusion	Hemophilia
Clotting Disorder	Pacemaker/Defibrillator		

Implants: _____ Cancer/Type: _____

Psychiatric Disorder(s): _____

Other illnesses and/or injuries: _____

Have you recently experienced any of the following?

Fevers	Weight Loss	Visual Loss	Double/Blurred vision
Wears Eyeglasses	Wears Contacts	Hearing Loss	Ringing in ears
Balance problems	Irregular Pulse	Hand Swelling	Foot Swelling
Nausea	Incontinence	Vomiting	Loss of appetite
Breast pain	Nipple Discharge	Shortness of Breath	Urinary problems
Seizures	Loss of coordination	Anxiety	Depression
Headaches	Fainting/Blacking Out	Arm Pain (L / R)	Arm Weakness (L/R)
Leg pain (L / R)	Leg weakness (L / R)	Rheumatoid Arthritis	Degenerative Arthritis

Family History

Family member	Alive	Deceased	Age	Health status or cause of death
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Patient Name: _____

Social History

Occupation: _____

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

Do you have children? ☐ Yes ☐ No

Do you smoke?
☐ No - I have never smoked
☐ No - I quit ____ years ago. Smoking history - ____ packs per day for _____ years
☐ Yes - _____ packs of cigarettes per day for _____ years
☐ Yes - cigars / pipe / chewing tobacco *(circle all that apply)*

Do you drink alcohol?

☐ Yes ☐ Daily ☐ Social Drinker ☐ More than once per week

☐ No ☐ No - I quit _____ years ago

Do you have a history of narcotic drug abuse? ☐ Yes ☐ No

Are you at risk for AIDS? *(i.e. sexual orientation, drug abuse, previous blood transfusion*)

☐ No ☐ Yes - Explain: _____

The above information is accurate to the best of my knowledge.

_____ _____

Patient or Guarantor Signature ***Date***