MIDWEST NEUROSURGERY & SPINE
Adult & Pediatric SPECIALISTS

COMPLETE ALL FIVE PAGES
BLACK INK ONLY

Checked-in: _____ *Updated*: _____

Patient Name: _____ Sex: M / F
(First) (MI) (Last)

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

Age: ____ D/O/B: _____ Social Security #: _____

Guarantor Information (person financially responsible for patient):

Name: _____ D/O/B: _____

Address: _____

Social Security #: _____ Relationship to Patient: _____ Marital Status: __

PHONE: Home: _____ Work: _____ Cell: _____

Employer: _____

Employer Address: _____

Insured's Name (if different than above): _____ D/O/B:_____

Relationship to Patient: _____ Social Security #: _____

Insured's Employer: _____ Phone #: _____

Emergency Contact (person not living with you we may contact in case of emergency):

Name: _____ Relationship: _____

Phone #s: _____

Referring Physician: _____
(please include first & last name)

Family Physician: _____
(please include first & last name)

Alternate Parent Information:

Name: _____ D/O/B: _____

Address: _____ Social Security #: _____

PHONE: Home: _____ Work: _____ Cell: _____

Employer: _____ Employer Address: _____

_____

Insurance:

Primary Insurance: _____ Policy Holder: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy Holder: _____

Policy #: _____ Group #: _____

_____

Auto Insurance (if due to an accident):

Policy Holder: _____ Claim #: _____

Company: _____ Phone #: _____

Address: _____

Date of Accident:_____ Person handling claim: _____

_____

Do you have an attorney or legal action current or pending for the condition for which you are seeking legal consultation?

If yes - Name of Attorney: _____

Address: _____ Phone #: _____

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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 *(circle)*	A	D		
Sister/Brother *(circle)*	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***