BRAIN AND SPINE CENTER
South Florida

4800 Linton Boulevard ▪ Suite E310 ▪ Delray Beach, FL 33445
Phone: 561-501-7445 Fax: 561-562-5061
Website: Brainandspinemds.com

Board Certified Neurosurgeons:
Evan M. Packer, MD FAANS, FACS ▪ Lloyd Zucker, MD FAANS ▪ Ronald Young II, MD, FAANS ▪ Martin Greenberg, MD, PhD

NEW PATIENT HISTORY QUESTIONNAIRE

Welcome to our office! Please answer this questionnaire to the best of your knowledge, which will allow the staff and doctor to know more about you and your medical condition. Along with this form you will need to have a picture ID, reports and films if applicable and your insurance information.

Full Name: ______________________ DOB: __|__|__ Age: ____ Email: ______________

Address: ______________________ City: ________ State: ___ Zip code: __________

Cel #: ______________ Home: ______________ Wk: ______________ Ext: ________

Emergency Contact: Name ______________ Relationship: ________ Ph #: ______________

PHARMACY NAME: ______________ Address: ______________ Ph#: ______________

Referral source: ☐ Doctor : ______________ PH #: __________ ☐ Internet ☐ Friend: __________

Check applicable selection : ☐ Refuse to answer

Sex: ☐ Male ☐ Female Ethnicity: ☐Hispanic ☐ Non Hispanic

Race: ☐White ☐African American ☐ Asian ☐ Pacific Islander ☐ Indian/Alaskan

Health Insurance: *We are in network and participating with Medicare and Multiplan*

Primary Insurance Name: ______________ ID# ______________ Phone______________

Are you the policy holder? ☐ Yes ☐ No, if no check ☐ spouse/other DOB: ________ and Name: ______________

Secondary Insurance Name: ______________ ID# ______________ Phone:______________

Are you the policy holder? ☐ Yes ☐ No, if no check ☐ spouse/other DOB: ________ and Name: ______________

Is this related to an *Auto accident*? ☐ No ☐ Yes, (if yes) accident date: ________ Auto Ins Name: ______________

Claim#: ______________ Adjuster Name: ______________ Adj Ph Number: ______________

Workman's Comp injury? ☐ No ☐ Yes, (if yes) injury date: ________ Insurance Name: ______________

Claim#: ______________ Adjuster Name: ______________ Adj Ph Number: ______________

Do you have an Attorney? ☐ No ☐ Yes, pls provide Name: ______________ PH: ______________

Authorization and release: I authorize release of my information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorization of payment from my insurance benefits to my doctor otherwise payable to me.

Patient Signature: ______________________ Date: ______________

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PATIENT HISTORY

Patient Name: ______________________ **Date of Birth:** ______________

Primary Physician: ______________ **Requested By:** ______________
Chief Complaint: ______________________________

	YES	NO	DATE
Is your condition related to a Motor Vehicle Accident?	___	___	___________
Work Related Injury?	___	___	___________

Medical History: Please check YES or NO for each disease

Yes	No		Yes	No	
___	___	AIDS or HIV+	___	___	Kidney disease
___	___	Arthritis	___	___	Migraine headaches
___	___	Asthma	___	___	Polio
___	___	Cancer (list condition below)	___	___	Rheumatic Fever
___	___	Diabetes	___	___	Stroke
___	___	Epilepsy	___	___	Thyroid disease
___	___	Heart disease (list condition below)	___	___	Tuberculosis
___	___	Hepatitis A B C (circle one)	___	___	Venereal disease
___	___	High blood pressure	___	___	Ulcers

Other: ______________________________

Surgical History: List all surgeries and dates (or year) that surgery was performed.

______________ ______________ ______________

______________ ______________ ______________

Allergies: Please check YES or NO for each medication. If yes, please list the reaction you experienced.

Yes	No		Yes	No	
___	___	Antibiotics ___________	___	___	Aspirin or Ibuprofen (circle one)
___	___	Morphine, Demerol or other Narcotics ___________	___	___	Tetanus antitoxin ___________
			___	___	Iodine or other antiseptics ___________
___	___	Novocain or anesthetics ___________	___	___	Food Intolerances ___________

Medications: **List all medications, supplements and aspirin products the dose (mg/gram) and frequency (once/twice a day)**

Drug Name	Dose	Frequency	Drug Name	Dose	Frequency

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Patient Name: ______________________________ **Date of Birth**: ________________

Family History: Please CIRCLE

	Current Age/Age at Death	Health Conditions and/or cause of death
Father: Alive/Deceased:	________	________________
Mother Alive/Deceased:	________	________________
Sister/Brother Alive/Deceased:	________	________________

Review of systems: Have you had any of the following in the past 6 months? Please check every line Yes or No

Constitutional:	Yes	No	**Respiratory:**	Yes	No	**Neurologic:**	Yes	No
Fever	__	__	Cough	__	__	Headaches	__	__
Weight loss	__	__	Short of breath	__	__	Numbness/tingling	__	__
Weakness	__	__	wheezing	__	__	Memory loss/confusion	__	__
Eyes:			**GI:**			**Integumentary:**		
Double vision	__	__	Nausea/vomiting	__	__	Easy bleeding/bruising	__	__
Blurred vision	__	__	Diarrhea	__	__	Skin rash	__	__
Visual loss / eye pain	__	__	Constipation	__	__	Varicose Veins	__	__
ENT:			Blood in stool	__	__	**Endocrine:**		
Sore throat	__	__	**GU:**			Excessive thirst	__	__
Earache	__	__	frequent urination	__	__	Cold/heat intolerance	__	__
Hearing loss	__	__	Incontinence	__	__	Decreased sex drive	__	__
Dizzy/vertigo	__	__	Nighttime urination	__	__	**Psychiatric:**		
CV:			**Musculoskeletal**			Depression	__	__
Chest pain	__	__	Joint pain	__	__	Anxiety	__	__
Palpitations	__	__	Neck pain	__	__	Insomnia	__	__
Swollen ankles	__	__	Back pain	__	__			

Social History: **Please check: __ Married__ Single__ Divorced __ Widowed __ # of children ________**
Do you, or have you ever smoked cigarettes? __yes__no; if yes, _____ packs/day for _____ years;
If you quite, how long ago?____Do you drink alcohol? __yes __no; if yes, how much-daily/weekly/or socially? __________
Do you now or have you ever used illicit drugs? __yes __no; if yes, specify type and frequency. ____________________

What is your occupation? ______________________________________

To the best of my knowledge, all questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changed in my health status.

Patient (guardian) Signature ______________________ Date Completed ____________

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Patient Name:______________________________

Please provide the names of your physicians and the office phone numbers;

Primary care/ Family Medicine/ Internist:______________________________

Phone number:______________________________

Neurologist:______________________________

Phone Number:______________________________

Cardiologist:______________________________

Phone Number:______________________________

Oncologist:______________________________

Phone Number:______________________________

Physiatrist/ Pain Management______________________________

Phone Number:______________________________

Please handwrite any other physician or specialist and the office phone number treating you:

____

____

____

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Authorization to Release Medical Record Information

NCSF will use and disclose your health information only for purposes of treatment, payment, and health care operations, unless you authorize us to use or disclose your health information for other purposes.

*You hereby authorize your physicians, hospitals, and health care facilities to disclose all or any part of your medical record to NCSF in connection with treatment, payment and health care operations for treatment and services provided to you by NCSF.

*This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may affect or limit the insurance coverage for treatment, services, or supplies provided by NCSF.

***Please list the names of family members or care givers we may speak with regarding your health information. We will not give any information out to anyone not listed on this form. ***

1 ______________________ 2 ______________________

3 ______________________ 4 ______________________

5 ______________________ 6 ______________________

OR:

☐ **Do not leave me a message or release information to anyone. Speak directly with me before releasing medical information**

______________________________ Date__________________

Signature of Patient or Guardian/Representative

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PATIENT FINANCIAL RESPONSIBILTY AGREEMENT

Financial Agreement

You agree to be responsible for and pay in full all charges by Neurosurgical Consultants of South Florida, L.L.C.'s ("NCSF") for treatment, services, and supplies provided to you. Payment is due upon receipt of our statement for services rendered. As a courtesy to you, NCSF will bill your insurance company, health maintenance organization or managed Care Company ("your health plan") for the medical services and supplies we provide to you. In billing your health plan, NCSF will rely upon the information you provide, including your current insurance identification card or other evidence of valid coverage. If your health plan changes in any way or your coverage terminates, please notify NCSF immediately so that we may update our records. It is particularly important to provide us with current and accurate billing information because the unpaid balance on your account will begin to incur an interest charge forty-five days after the date of the invoice. Interest will accrue at a rate of 1-1/2% per month.

If your health plan is a health maintenance organization, you are only responsible under Florida law for payment of deductibles, co-payments and charges for non-covered services as specified in your plan. As a patient enrolled in a health maintenance organization, you may be required to first contact your primary care physician before seeking any other medical care. Your health plan may require that your primary care physician or a contracted specialist physician refer you to us or obtain a prior authorization before you are referred to us for any medical services. If you do not comply with your health plan's policies and procedures, payment for the services we render could become your responsibility. If you are unsure of your obligations, please ask us. We will be pleased to help you clarify your obligations at any time. But, as the member of the health plan, it is your responsibility to ensure that you meet the obligations set forth in your plan documents.

NCSF's efforts to bill and collect on your behalf from your health plan and NCSF's acceptance of payment from your health plan will not relieve you of your obligation to make payment to NCSF in full. The amount your health plan pays NCSF may be less than the full charges or the amount you owe to NCSF. NCSF will credit all payments received from your health plan to your account and will bill you for the balance, unless otherwise provided under Florida law or if NCSF contracts with your health plan to accept the amount paid by them as payment in full.

All deductibles and co-payments required by your health plan are your responsibility. NCSF is prohibited by law from waiving deductibles and co-payments.

If payment is not made at any time and NCSF engages an attorney to assist in collection, you will be responsible for all fees and costs NCSF incurs in connection with its collection efforts. Your responsibility for the fees and costs NCSF incurs will be in addition to the charges and interest accrued on your account.

Advance Payment

You are required to make an advance payment of $________.___ to NCSF prior to the provision of any further medical services. NCSF will apply this payment to your account and bill you for any balance due. If we bill a health plan on your behalf and receive payment, we will credit the payment to your account and send you a statement reflecting the balance due. If at the time of the conclusion of our services there is a credit balance on your account, we will refund the balance to you.

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Assignment of Insurance Benefits

You hereby authorize payment to be made directly to NCSF and assign to NCSF all Medicare and other insurance benefits that may be due and payable to you or on your behalf for any serviced and supplies rendered to you by NCSF. You hereby authorize NCSF and any other holder of medical or other information about you, including any Medigap insurer, to release to the Social Security Administration, the Centers for Medicare and Medicaid Services, and their agents, intermediaries and carriers, any information needed to determine the benefits or benefits payable to you for any claim with respect to NCSF's provision of health care services and supplies. Where Medicare and Medicaid benefits are applicable, you certify that the information given in applying for payment under Title XVIII or XIX of the Social Security Act is complete and correct. **You authorize NCSF to use this Agreement as evidence of your consent to bill and receive payment for health care services and supplies provided to you by NCSF. You further acknowledge that this assignment of benefits does not in any way relieve you of your liability to make payment to NCSF, and that you will remain financially responsible to NCSF until all charges for which you are legally responsible are paid in full. In the event the insurance carrier mistakenly sends payment for the claim directly to me, I agree that I will remit payment in its entirety to Neurosurgical Consultants of South Florida.**

Authorization for Appointment of Designated Appeal Representative of Designated Appeal Representative

I________________________________, authorize Neurosurgical Consultants of S. Fl, LLC to act as my representative in connection with the filing of an appeal on my behalf regarding a denial for the above referenced date(s) of service. I authorize (insurance carrier)________________________to release any of my protected health information including benefits and policy information to Neurosurgical Consultants of S. Fl, LLC for the purpose of resolving this appeal. I understand that this information is privileged and confidential and will only be released as specified in this authorization or as required pr permitted by law.

I understand that I may revoke this authorization at any time by mailing a written notice to (insurance carrier)______________________. I understand that revoking this authorization will not affect any action taken prior to my notice of revocation. My designated appeals representative also has the fight to rescind consent at any time.

I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand that I am granting my consent for my representative to file an appeal on my behalf.

I have read and understand each of the above paragraphs and I acknowledge and accept these terms and conditions.

x____________________________________ Date:_________________________
Signature of Patient or Guardian/Representative

_____________________________________ _____________________________
Print Name Patient's Social Security Number

____
Signature of Designated Representative of
Neurosurgical Consultants of S. FL, LLC

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Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________, have received a copy of this office's Notice
(Patient's Name)
of Privacy Practices.

Signature of Patient (Responsible Party): ______________________________

Witness: ______________________________

Date: ______________________________

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_________ Individual refused to sign

_________ Communication barriers prohibited obtaining the acknowledgement

_________ An emergency situation prevented us from obtaining the Acknowledgement

_________ Other ______________________________