CAPITAL NEUROLOGICAL SURGEONS

New Patient Registration Form

General Information (Please Print)

Name: ________________________ DOB: ______________ Sex: ❒ M ❒ F

SSN: ____________________ Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Primary Address: ____

City: ________________________ State: ______________ Zip: ______________

Phone(s): Home ______________ Cell ______________ Work ______________

Emergency Contact: ____________________ Relationship: __________ Phone: ______________

E-Mail: ____

Pharmacy Name: ________________________ Pharmacy Phone: ______________

Race: ______________ Ethnicity: ______________ Language: ______________

Have you or anyone in your family been seen in our office before? ______________________

Doctor Information

Referring Physician: ________________________ Specialty: ______________

Primary Care Physician: ________________________ Phone: ______________

Primary Insurance

Insurance Name: ________________________ ID: ______________

Subscriber's Name: ____________________ DOB: ______________ Copay: ______________

Secondary Insurance

Insurance Name: ________________________ ID: ______________

Subscriber's Name: ____________________ DOB: ______________ Copay: ______________

Workers' Compensation

Work Comp Carrier: ________________________ Employer: ______________

Claim Number: ________________________ Date of Injury: ______________

Adjuster: ____________________Phone: ______________ Fax: ______________

I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I assign medical and/or major medical insurance benefits to Capital Neurological Surgeons. I authorize Capital Neurological Surgeons to release all information necessary to secure payment and to file on my behalf any complaints to the California Insurance Commissioner. I also agree to allow Capital Neurological Surgeons and affiliates to contact me with patient satisfaction surveys' in an effort to improve your patient care and overall experience.

____ ______________________

Signature **Date**

Name ____ Age __________ Height __________ Weight __________

REASON FOR NEUROSURGICAL CONSULTATION: What is the main problem for which you are here? (back pain, neck pain, headache, etc) ____

ALLERGIES TO MEDICATIONS OR LATEX: ____

MEDICATIONS: Please list all current medications and dosages ____

____

____

CHRONIC PROBLEMS: Check any of these conditions that apply to you

❒ High Blood Pressure	❒ Arthritis	❒ Alcoholism	❒ Skin Disease
❒ Diabetes	❒ Depression	❒ Hepatitis	❒ Sleep Apnea
❒ Fibromyalgia	❒ Cancer	❒ Emphysema	❒ Seizures
❒ Heart Disease	❒ Kidney Problems	❒ Heartburn	❒ Asthma
❒ Stroke	❒ Anemia	❒ History of Drug Use	❒ Other ________________________

Are you currently or have you ever been under the care of a cardiologist? ❒ Yes ❒ No

OPERATIONS: Please list any surgeries that you have had along with the year it took place _______________________

____

FAMILY HISTORY: Please mark if any of your immediate family had any of the following conditions – please note the relationship of the individual

❒ High Blood Pressure ____________	❒ Seizures ______________________	❒ Diabetes _____________________
❒ Anesthesia Problems ___________	❒ Stroke _______________________	❒ Birth Defects __________________
❒ Heart Disease _________________	❒ Cancer _______________________	❒ Kidney Disease ________________

SOCIAL HISTORY:

Education (number of years, degrees): ____________________ Hand you write with: ❒ Right ❒ Left

Occupation: ________________________ Employer: ______________________ Years Employed _______________

Are you working now? ❒ Yes ❒ No If not, when is the last day you worked? _____________________________

HABITS:

Do you smoke? ❒ Yes ❒ No If not, have you ever smoked in the past? ❒ Yes ❒ No

Do you use smokeless tobacco? ❒ Yes ❒ No If not, have you ever used it in the past? ❒ Yes ❒ No

Do you drink alcohol? ❒ Yes ❒ No If so, how often? ❒Occasionally ❒ Weekly ❒ Daily

PAIN REPORT:

How long ago did your pain begin? ____

On a scale of 0-10, with 0 being no pain and 10 being the worst pain imaginable, what is your pain level? _____________

Do you have any of the following?

Sharp Pain ❐ Yes ❐ No If so, where? ___________________________________ ❐ Constant ❐ Intermittent

Burning Pain ❐ Yes ❐ No If so, where? ___________________________________ ❐ Constant ❐ Intermittent

Aching Pain ❐ Yes ❐ No If so, where? ___________________________________ ❐ Constant ❐ Intermittent

Numbness ❐ Yes ❐ No If so, where? ___________________________________ ❐ Constant ❐ Intermittent

Tingling ❐ Yes ❐ No If so, where? ___________________________________ ❐ Constant ❐ Intermittent

Weakness ❐ Yes ❐ No If so, where? ___________________________________ ❐ Constant ❐ Intermittent

What makes the pain better? ____

What makes the pain worse? ____

Does the pain make it difficult to do any of the following daily activities? (Please circle all that apply)

Bathing	Eating	Dressing	Walking
Toileting	Climbing Stairs	Driving	Sleeping

Have you had any of the following tests/studies done within the past year related to the reason you are being seen in this office?

MRI ❐ Yes ❐ No If so, when and where was it done? ____

CT Scan ❐ Yes ❐ No If so, when and where was it done? ____

X-Ray ❐ Yes ❐ No If so, when and where was it done? ____

EMG ❐ Yes ❐ No If so, when and where was it done? ____

CONSERVATIVE MANAGEMENT THAT YOU HAVE TRIED FOR THIS MEDICAL CONDITION:

Medications (Pain medicine/anti-inflammatories) ❐ Yes ❐ No

Names of medications tried: ____

Duration: Start __________________________ End __________________________

Effectiveness: ❒ Reduced pain from ________ to ________ on a scale of 0-10

❒ Did not have any effect

Physical and/or Occupational Therapy ❒ Yes ❒ No

Location: ____

Duration: Start __________________________ End __________________________

Effectiveness: ❒ Reduced pain from ________ to ________ on a scale of 0-10

❒ Did not have any effect

Injections (epidural steroid, facet block, radio frequency ablation, selective nerve root block) ❒ Yes ❒ No

Number of injections tried: ________________________

Duration: Start __________________________ End __________________________

Effectiveness: ❒ Reduced pain from ________ to ________ on a scale of 0-10

❒ Did not have any effect

Assistive Devices Used ❒ Cane ❒ Walker ❒ Wheelchair ❒ Back Brace / Neck Collar

Duration: Start __________________________ End __________________________

If using a cane or walker, how far can you walk with this device? ____

Weight Loss ❒ Yes ❒ No

How many pounds have you lost? __________________

Effectiveness: ❒ Reduced pain from ________ to ________ on a scale of 0-10

❒ Did not have any effect

Activity Modification ❒ Yes ❒ No

What activities have you made changes to? ____

Duration: Start __________________________ End __________________________

Effectiveness: ❒ Reduced pain from ________ to ________ on a scale of 0-10

❒ Did not have any effect