Coastal NeuroSurgery P.A.

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Diplomate American Board of Neurological Surgery

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Telephone (732) 341-1881
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PATIENT INFORMATION Patient #_____

NAME OF PATIENT _____AGE _____

ADDRESS_____
Street City State Zip Code

SOCIAL SECURITY #_____ DATE OF BIRTH_____

HOME (____)_____ CELL (____)_____WORK (____)_____

EMERGENCY CONTACT_____ PHONE (___)_____

REFERRING M.D._____ ADDRESS_____

PHARMACY: NAME_____ADDRESS_____PHONE(____)_____

REASON FOR YOUR VISIT TODAY:_____

DO YOU SMOKE? NO_____ YES____ PACKS PER DAY SMOKED:_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO_____ IF YES, PLEASE LIST:
_____

PLEASE CIRCLE YES OR NO:

ARE YOU ALLERGIC TO SHELLFISH OR IODINE DYE?	YES	NO
ARE YOU ALLERGIC TO LATEX?	YES	NO
DO YOU TAKE ASPIRIN OR VITAMIN E?	YES	NO
DO YOU TAKE ADVIL, MOTRIN, ALEVE OR NAPROSYN?	YES	NO
DO YOU USE ANY ERECTILE DYSFUNCTION (ED) MEDICINES?	YES	NO

LIST ALL MEDICATIONS AND DOSAGE:_____

_____

_____

LIST ALL HOSPITALIZATIONS AND SURGERIES WITH DATES:_____

_____

_____

DO YOU HAVE A LIVING WILL (ADVANCE DIRECTIVE)? YES_____ NO _____

PERSON IN CHARGE:_____ PHONE # _____

CHECK IF YOU HAVE HAD:

- ❑ ANGINA
- ❑ HEART ATTACK
- ❑ HEART MURMUR
- ❑ HYPERTENSION
- ❑ RHEUMATIC FEVER
- ❑ SHORTNESS OF BREATH
- ❑ EASY BRUISING OR BLEEDING
- ❑ CORNEAL TRANSPLANT: WHEN_____
- ❑ SEIZURES
- ❑ DIABETES
- ❑ HEPATITIS/AIDS/HIV
- ❑ KIDNEY DISEASE
- ❑ ULCER DISEASE
- ❑ LUNG DISEASE
- ❑ THYROID DISEASE
- ❑ SEX OR GROWTH HORMONES

ETHNICITY: Are you Hispanic or Latino? YES ___ NO ___

RACE:
- ❑ White
- ❑ Black or African American
- ❑ Asian
- ❑ Multiple races
- ❑ American Indian or Alaska Native
- ❑ Native Hawaiian or other Pacific Islander

LANGUAGE SERVICES: If you speak any of the following, language assistance services, free of charge is available to you. Please circle the one for which you need assistance: **Spanish, Chinese, Korean, Portuguese, Gujarati, Polish, Italian, Arabic, Tagalog, Russian, French Creole, Hindi, Vietnamese, French, Urdu.**

INSURANCE INFORMATION:

PRIMARY INSURANCE CO. NAME_____
ID #_____ GROUP # _____
ADDRESS_____

SECONDARY INSURANCE CO. NAME _____
ID #_____ GROUP # _____
ADDRESS_____

IS THIS WORK RELATED? _____ AUTO ACCIDENT?_____ OTHER ACCIDENT

I authorize all medical and/or surgical benefits, including Major Medical, Medicare, private insurance or health plans to COASTAL NEUROSURGERY. I am responsible for all charges incurred for my medical care. If Coastal Neurosurgery, P.A. is unable to collect the monies due us in a reasonable time, a finance charge of 1.5% per month will be added to your balance each month. If your account is sent to a collection agency, all collection costs and legal fees will be added to your account. I authorize the release of any medical information necessary to process my claim.

PLEASE SIGN_____ DATE _____

HIPPA DISCLOSURE

Coastal Neurosurgery, P.A. is committed to keep all information about you and your care private. We will notify you if there is any compromise to the security or privacy of your health, insurance or financial information (i.e., a "Red Flag" or "Breach"). We may use medical information about you to help with and coordinate your treatment with other doctors, nurses, therapists or other medical personnel.
If there are any health care professionals that you do **NOT** want us to release information to, please list:

_____
_____
_____
_____

We may be required to disclose medical information about you to insurance companies when required for payment or reimbursement for services. You have a right to inspect, read or obtain a copy or limit the distribution of your medical record.
To contact you with appointment, lab or test information we may need to call you by phone. If you are not available, can we leave appointment and lab or test results.
1. On your answering machine or voice mail? (circle one) YES NO
2. With a person who answers your phone? (circle one) YES NO

Is there anyone who might answer the phone that we should **NOT** leave this information with, please list:

_____ _____
_____ _____

If you have any questions about your medical record or privacy, you may read a more detailed description, available on request. Dr. Hartwell is the "Privacy Officer" but anyone on staff can answer your questions.

Please sign to show you understand the above:

Signature: _____ Date _____