

Coastal NeuroSurgery P.A.

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Diplomate American Board of Neurological Surgery

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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: _____

PATIENT _____

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:
- English
 - Spanish
 - Italian
 - French
 - Japanese
 - Portuguese
 - Russian
 - _____

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 _____