



Associates In Neurosurgery

New Patient Auto Information

Name: Last _____ First _____ MI _____

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Fax Number: _____

Cell Phone: _____ E-mail Address: _____

SS#: _____ - _____ - _____ Date of Birth _____ Age _____ Male Female

Employer: _____ Occupation: _____

Address: _____

Employee Status: Full-Time Part-Time Not Employed Retired *or* Student Status: Full-time Part-Time

Marital Status: Single Married Divorced Widowed Spouse Name: _____

Do you have a Living Will? _____

Do you have a Power Of Attorney? _____ If yes, list their name and Number: _____

Referring Physician

Primary Care Physician

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: () _____

Telephone Number: () _____

Fax Number: () _____

Fax Number: () _____

Emergency Contact:

Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone #: _____ Cell Phone: _____ Relationship to Patient _____

Auto Insurance: _____

Address: _____

Phone Number: _____ Fax Number: _____

Policy #: _____ Claim #: _____ Date of accident: _____

Adjuster Name: _____ Phone Number: _____

Primary Health Insurance: _____

Address: _____

Phone Number: _____ Fax Number: _____

Group #: _____ Policy #: _____

Secondary Health Insurance: _____

Group #: _____ Policy #: _____ Phone Number: _____

Attorney Name: _____

Address: _____

Phone #: _____ Fax: _____

***** DISREGARD THIS SECTION IF THE PATIENT IS THE PRIMARY INSURANCE POLICY HOLDER**

Insured Name: Last _____ First _____ MI _____

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS#: _____ - _____ - _____ Date of Birth _____ Relation to Patient: _____

I authorize the release of any medical information necessary to process an insurance claim for services rendered to me. I also authorize payment of medical benefits directly to Associates in Neurosurgery for services rendered to me. I accept full responsibility for my bill if my insurance carrier does not pay.

Date: _____ Patient Signature: _____



OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered**. This means that those services have **already been provided**.

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a **billing error**, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (<i>PRINT or TYPE</i>)	Signature	Date
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The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an **invalid or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (*Signature by his/ her own hand*):

Name (<i>PRINT or TYPE</i>)	Signature	Date
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Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.



Associates In
Neurosurgery

532 Virginia Drive Orlando, Florida 32803 · Phone: 407-898-8644 · Fax: 407-898-8646 · Web: www.ain.md · E-mail: info@ai-neurosurgery.com

Phillip G. St. Louis, M.D.

Tara L. Batz, PA-C

Health History Spinal Packet

Account # _____

Date: _____

Name: *Last* _____ *First* _____ *MI* _____

SS#: _____ - _____ - _____ DOB: _____ Age _____ Gender: Male Female

Height: _____ Weight: _____ Left Handed Right Handed

Occupation: _____ Occupational Exposure? _____

Referring Physician

Primary Care Physician

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: () _____

Telephone Number: () _____

Fax Number: () _____

Fax Number: () _____

Chief Complaint-(The main reason for your visit)

Pain--Side: _____ Location: _____

Numbness --Side: _____ Location: _____

Weakness --Side: _____ Location: _____

Other: _____

Describe the quality of the symptom: Sharp Dull Burning Aching

Other: _____

Describe the intensity of the symptom: Mild Moderate Severe

Other: _____

Describe the frequency of your symptom: Constant Intermittent Daily

Other: _____

What makes it better? _____

What makes it worse? _____

How long have you had this problem? _____

Your problem is the result of a: Car Accident Work Accident Don't Know

Other: _____

Since the start of your problem, it has gotten: Worse Better Stayed the Same

Have you ever had similar symptoms prior to above: No Yes

If yes, explain: _____

Have you had prior spine surgery: No Yes If yes, explain: _____

Were you able to work since the symptoms started: No Yes Some On and Off

Have you tried physical therapy: No Yes If yes, did it work: No Yes Temporarily

Have you had epidural blocks: No Yes If yes, did it work: No Yes Temporarily

Have you had any other methods of treatment: _____

Have you had other tests: MRI CT Myelogram EMG/NCT

Nerve Blocks Angiogram Physical Therapy Other _____

Litigation pending (optional): Yes No

Patient Name: *Last* _____ *First* _____ *MI* _____ *DOB:* _____

Medical Problems: Diabetes Hypertension Heart Disease Stroke Heart Attack
 Cancer _____ Other _____

Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia? Yes No

Current Medication(s)	Dose	Frequency

Do you take aspirin or any aspirin products? _____ If yes, How much and how often? _____

ALLERGIES TO MEDICATIONS AND THE REACTION:

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (Mom's)	A	D		
Grandfather (Mom's)	A	D		
Grandmother (Dad's)	A	D		
Grandfather (Dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed Separated

Are you pregnant? _____ Breastfeeding _____ Do you have children? _____ How many? _____

Do you live alone? _____ Who lives with you? _____

Do you travel? _____ How often in a year? _____

Do you smoke? Yes, I've smoked _____ packs of cigarettes per day for _____ years.

Yes, I've smoked cigars or a pipe for _____ years.

No, I have never smoked

No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

Do you drink alcohol? No, never No, but I used to Rarely Daily

1 or more times a week 1 or more times a month

How often do you have caffeine? _____ Exercise routine? _____

Are you at risk for Immune Deficiency (e.g. HIV/AIDS sexual orientation/behavior, drug abuse, previous blood transfusion?) No Yes, Please Explain: _____

REVIEW OF SYSTEMS

Name: Last: _____ First: _____ DOB: _____

Are you currently, or have had problems with the following:

<u>Constitutional</u>			<u>Genitourinary</u>		
Fever	Yes	No	Urinary Tract Infections	Yes	No
Weight Loss	Yes	No	Painful Urination	Yes	No
Excessive fatigue	Yes	No	Blood in Your Urine	Yes	No
Chills/Night Sweats	Yes	No	Difficulty Starting and Stopping Stream	Yes	No
			Incontinence	Yes	No
<u>Eyes</u>			Kidney Stones	Yes	No
Wear Glasses	Yes	No	Prostate Cancer (males)	Yes	No
-Date of Last Exam _____			Endometriosis (females)	Yes	No
Glaucoma/Partial Vision Loss	Yes	No	Uterine or Cervical Cancer (females)	Yes	No
Cataracts	Yes	No			
Painful Vision	Yes	No	<u>Musculoskeletal</u>		
			Neck Pain	Yes	No
<u>Ear, Nose, Throat, and Mouth</u>			Arm or Leg Weakness	Yes	No
Hearing Loss	Yes	No	Back Pain	Yes	No
Ear Infections	Yes	No	Arm or Leg Pain	Yes	No
Ringing in Ears	Yes	No	Joint Pain or Swelling	Yes	No
-Circle: Left Right Both	Yes	No	Arthritis	Yes	No
Balance Disturbance (e.g. Vertigo or Spinning)	Yes	No	Muscle/Pain or Tenderness in Joints	Yes	No
Nosebleeds	Yes	No			
Nasal Congestion	Yes	No	<u>Integumentary</u>		
Nasal Drainage	Yes	No	Skin Disease	Yes	No
-Amount _____ Color _____			Skin Cancer	Yes	No
Inability to Smell	Yes	No	Breast Pain, Tenderness, or Swelling	Yes	No
Sinus Problems	Yes	No	Nipple Discharge (females)	Yes	No
Sinus headaches	Yes	No			
Sore Throats	Yes	No	<u>Neurological</u>		
Mouth Sores	Yes	No	Fainting Spells or Blacking Out	Yes	No
			Seizures---Last One _____	Yes	No
<u>Cardiovascular</u>			Problems with Memory	Yes	No
Chest Pain or Angina	Yes	No	Disorientation	Yes	No
High Blood Pressure	Yes	No	Difficulty with Speech	Yes	No
Irregular Pulse	Yes	No	Inability to Concentrate	Yes	No
Heart Murmur	Yes	No	Double or Blurred Vision	Yes	No
High Cholesterol	Yes	No	Face Weakness	Yes	No
Swelling in Feet or Hands	Yes	No	Coordination in Arms/or Legs	Yes	No
Leg Pain While Walking	Yes	No	Headaches	Yes	No
			Stroke	Yes	No
<u>Respiratory</u>			<u>Psychiatric</u>		
Asthma	Yes	No	Anxiety	Yes	No
Chronic Cough	Yes	No	Depression	Yes	No
Emphysema	Yes	No	Other Psychiatric Disorder	Yes	No
Shortness of Breath	Yes	No			
Bronchitis	Yes	No	<u>Endocrine</u>		
Pneumonia	Yes	No	Diabetes	Yes	No
Lung cancer	Yes	No	Thyroid Disease	Yes	No
Bloody Sputum	Yes	No	Increase Appetite	Yes	No
			Excessive Thirst or Urination	Yes	No
<u>Gastrointestinal</u>			Hormone Problems	Yes	No
Indigestion or Pain with Eating	Yes	No			
Nausea	Yes	No	<u>Hematology/Lymphatic</u>		
Vomiting	Yes	No	Anemia	Yes	No
Blood in Your Vomit	Yes	No	Hemophilia	Yes	No
Liver Disease	Yes	No	Bleeding Tendencies	Yes	No
Jaundice	Yes	No	Persistent Swollen Glands or Lymph Nodes	Yes	No
Abdominal Pain	Yes	No	Blood Transfusion	Yes	No
Change in Your Bowel Habits	Yes	No			
Ulcers or Gastritis	Yes	No	<u>Allergic/Immunologic</u>		
Colon Cancer	Yes	No	Food Allergies	Yes	No
			Inhalant (nasal) Allergies	Yes	No
			Immunology Disorders	Yes	No

I have reviewed this information with the patient.

Physician Signature _____

Date _____



**Associates In
Neurosurgery**

Phillip G. St. Louis, M.D., FACS

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____

Social Security Number: _____ Date of birth: _____

Name of legal guardian or parent of minor: _____

I do hereby request that my medical records to be released to:

Associates in Neurosurgery
532 Virginia Drive
Orlando, FL 32803
Phone: (407) 898-8644
Fax: (407) 898-8646

I hereby request that the following records be sent:

- | | | |
|---|---|--|
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Consultation Records | <input type="checkbox"/> Lab/Pathology Reports |
| <input type="checkbox"/> EMG/NCT Reports | <input type="checkbox"/> Work Release Forms | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> X-Ray/Test Results | <input type="checkbox"/> All medical records | <input type="checkbox"/> Other _____ |

Patient or Legal Guardian/Parent Signature

Date

CONFIDENTIALITY NOTE

The information contained in this transmission is absolutely confidential and intended for the use of the addressee listed above and no one else. If you are not the intended recipient, or the employee or agent responsible to deliver this document to the intended recipient, you are hereby notified that any dissemination or copying of this facsimile is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by telephone.



**Associates In
Neurosurgery**

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize Associates in Neurosurgery to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify to carry out my treatment, payment and health care operations I understand that while this consent is voluntary, if I refuse to sign this consent, Associates in Neurosurgery can refuse to treat me.

I have been informed that Associates in Neurosurgery has prepared a notice ("Notice"), which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Associates in Neurosurgery in writing, but if I revoke my consent; such revocation will not affect any actions that Associates in Neurosurgery took before receiving my revocation.

I understand that Associates in Neurosurgery reserves the right to change its privacy practices and that I can obtain such notice changes upon request.

I understand that I have the right to request that Associates in Neurosurgery restrict how my individual identifiable health information is used and/or disclosed to carry out treatment, payment or health operations I understand that Associates in Neurosurgery does not have to agree to such restrictions, but that once such restrictions are agreed to, Associates in Neurosurgery must adhere to such restrictions.

I authorize the names listed below to receive my medical information (e.g. Family, friends, fax, e-mail, phone number, etc...)

1. _____ Phone Number: _____
2. _____ Phone Number: _____
3. _____ Phone Number: _____

We will contact you by e-mail, fax, mail, or phone unless you otherwise notify our office in writing below.

Signature of Patient or Patient's Representative

Date

Print Name

Relationship to the patient

Associates in Neurosurgery

Acknowledgement Form

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name

Print Name: _____

Signature: _____

Witness: _____

Date: _____