



# Associates In Neurosurgery

## New Patient Information

Name: *Last* \_\_\_\_\_ *First* \_\_\_\_\_ *MI* \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

SS#: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: ( ) \_\_\_\_\_

Fax Number: ( ) \_\_\_\_\_

### Primary Care Physician

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: ( ) \_\_\_\_\_

Fax Number: ( ) \_\_\_\_\_

### Emergency Contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Pre-Certification #: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

### **\*\*\* 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: \_\_\_\_\_



**Associates In  
Neurosurgery**

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

**Phillip G. St. Louis, M.D.**  
**Tara L. Batz, PA-C**  
*Health History General/ Brain Packet*

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)

Primary reason for your visit: \_\_\_\_\_

Symptoms: \_\_\_\_\_

What makes your problem worse? \_\_\_\_\_

What makes your problem feel better? \_\_\_\_\_

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, has it gotten worse since it started: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

What have you had done for your problem:  MRI  CT  Myelogram  EMG/NCT  
 Nerve Blocks  Angiogram  Physical Therapy  Other \_\_\_\_\_

Have you had similar problems before: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

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><b>Constitutional</b></u>			<u><b>Genitourinary</b></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
<u><b>Eyes</b></u>			Incontinence	Yes	No
Wear Glasses	Yes	No	Kidney Stones	Yes	No
-Date of Last Exam _____			Prostate Cancer (males)	Yes	No
Glaucoma/Partial Vision Loss	Yes	No	Endometriosis (females)	Yes	No
Cataracts	Yes	No	Uterine or Cervical Cancer (females)	Yes	No
Painful Vision	Yes	No	<u><b>Musculoskeletal</b></u>		
<u><b>Ear, Nose, Throat, and Mouth</b></u>			Neck Pain	Yes	No
Hearing Loss	Yes	No	Arm or Leg Weakness	Yes	No
Ear Infections	Yes	No	Back Pain	Yes	No
Ringing in Ears	Yes	No	Arm or Leg Pain	Yes	No
-Circle: Left Right Both	Yes	No	Joint Pain or Swelling	Yes	No
Balance Disturbance (e.g. Vertigo or Spinning)	Yes	No	Arthritis	Yes	No
Nosebleeds	Yes	No	Muscle/Pain or Tenderness in Joints	Yes	No
Nasal Congestion	Yes	No	<u><b>Integumentary</b></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	<u><b>Neurological</b></u>		
Sore Throats	Yes	No	Fainting Spells or Blacking Out	Yes	No
Mouth Sores	Yes	No	Seizures--Last One _____	Yes	No
<u><b>Cardiovascular</b></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
<u><b>Respiratory</b></u>			Stroke	Yes	No
Asthma	Yes	No	<u><b>Psychiatric</b></u>		
Chronic Cough	Yes	No	Anxiety	Yes	No
Emphysema	Yes	No	Depression	Yes	No
Shortness of Breath	Yes	No	Other Psychiatric Disorder	Yes	No
Bronchitis	Yes	No	<u><b>Endocrine</b></u>		
Pneumonia	Yes	No	Diabetes	Yes	No
Lung cancer	Yes	No	Thyroid Disease	Yes	No
Bloody Sputum	Yes	No	Increase Appetite	Yes	No
<u><b>Gastrointestinal</b></u>			Excessive Thirst or Urination	Yes	No
Indigestion or Pain with Eating	Yes	No	Hormone Problems	Yes	No
Nausea	Yes	No	<u><b>Hematology/Lymphatic</b></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	<u><b>Allergic/Immunologic</b></u>		
Ulcers or Gastritis	Yes	No	Food Allergies	Yes	No
Colon Cancer	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: \_\_\_\_\_