Premier Brain & Spine Institute, Inc.
(All information MUST be completed in order to bill your insurance company)

Patient Name Last: ________________________________ First: ________________________________ MI: ______

Date of Birth: __________________ Age: __________ Patient Social Security: _____________________________

Street Address: ____ Apt #: ___________

City: ____ State: ____________ Zip: ______________________

Phone # - Home: _______________________ Cell: _________________________ Work: _________________________

Email: ____

Marital Status (Circle One): Married Single Divorced Widowed Separated

Sex (Circle One): Male Female

Primary Language Spoken: _________________________________

Ethnicity (Circle one): Hispanic/Latin American Not Hispanic or Latino Other Refuse to Report

Race: (Circle all that apply) American Indian or Alaska Native Asian Native Hawaiian or Other Pacific

White Black or African American Hispanic Other Race Other Pacific Islander Refuse to Report

Employer: ____

Person to notify in an Emergency: ________________________________ Relation: __________________________

Phone number: ____

Preferred Pharmacy: Name: __________________________________ Phone Number: _______________________

Pharmacy Address: ____

City: ______________________________________ State: _________________ Zip: _______________________

Primary Insurance Company (Please Provide Copy of Card) :____________________________________

Subscriber (if other than patient)

Last Name: _______________________________ First: _____________________________ MI:________

Subscriber's Birth date: __________________ Social Security Number: ____________________________

Subscriber's Employer : ____

Subscriber's Identification Number: __________________________________

Group Number: ____

Relationship to Patient: ____

I understand that I am liable for expenses incurred which are not covered under my plan. I understand that all co-payment, deductibles and/ or non covered services are to be paid in full at the time of service. I hereby authorize the release of any information to my insurance company necessary claims. I hereby authorize my insurance company to make payments directly to the physician. I have read and agree to the policies and will abide by them.

Signed: ____ Date: _______________________

Patient Name: ______________________________ Appointment Date: ________________
Birthdate: ________________ Age: ________

Reason for today's visit:

____

____

Is this the result of a specific injury or accident? Yes ☐ NO ☐

Are you involved in litigation regarding this condition? Yes ☐ NO ☐

Date of accident: ________________ Type of accident: ____________________________

It is important for us to communicate with your physician about the result of your evaluation. Please provide the names and **full addresses** of all your individuals authorized to receive reports from us. Please also sign the space below to indicate your consent to release your medical information to these individuals.

If you wish to revoke your authorization to send copies of this evaluation and subsequent visits to any or all individuals listed below, please send a written letter to the clinic revoking consents to release this information and specify which individuals you are referring to.

1. Referring Physician: ____

Street Address: ____

City, State, Zip: __________________________________ Phone #: ____________________

2. Primary Care Physician: ____

Street Address: ____

City, State, Zip: __________________________________ Phone #: ____________________

3. Name: __________________________ Indicate primary care or subspecialty: ____________

Street Address: ______________________________________

City, State, Zip: __________________________________ Phone #: ____________________

4. Name: __________________________ Indicate primary care or subspecialty: ____________

Street Address: ______________________________________

City, State, Zip: __________________________________ Phone #: ____________________

Patient or legal guardian's authorized signature: __________________________ Date: __________

Patient Name: ____ Date: __________________

Past Medical History:
Have you ever been **diagnosed** with any of the following conditions or had any of the procedures listed below? *Circle Yes or No. If yes, please give an explanation.*

System	Patient Comments	Physician Comment
CARDIOVASCULAR		
Arial fibrillation	YES NO	
Blood clotting disorder	YES NO	
Carotid artery disorder	YES NO	
Congestive heart failure	YES NO **Level**________ **Date**________	
Elevated cholesterol	YES NO	
Heart murmur	YES NO	
Heart attack/angina	YES NO	
Heart surgery/angioplasty	YES NO	
High blood pressure	YES NO	
Prosthetic/artificial heart value	YES NO	
Blockage of arm or leg blood vessels	YES NO	
GASTROINTESTINAL/ GENITOURINARY/RESPISTORY		
Stomach ulcers	YES NO	
Liver disease/hepatitis	YES NO	
Kidney/bladder disease	YES NO	
Lung disease	YES NO	
Tuberculosis	YES NO	
Asthma	YES NO	
COPD	YES NO	
NEUROLOGICAL		
Brain tumor	YES NO	
Convulsions/seizure disorder/epilepsy	YES NO	
Head injury	YES NO	
Migraine headaches	YES NO	
Parkinson's disease	YES NO	
Stroke or TIA	YES NO	
Nerve or muscle disease	YES NO	
Other neurological disease	YES NO	
OTHER		
Alcohol dependency	YES NO	
Cancer	YES NO Type: __________________	
Diabetes	YES NO	
Drug abuse	YES NO	
Immune system disorder	YES NO	
Thyroid disease	YES NO	
Toxic exposure	YES NO	
Sexually transmitted disease	YES NO	

Other Medical Problems/History: (Please list all medical conditions not listed above)

____
____
____

Patient Name: ____ Date: __________________

Previous operations/hospitalizations

Date	Hospital	Problem/Operation
______________	________________________	_________________________
______________	________________________	_________________________
______________	________________________	_________________________
______________	________________________	_________________________
______________	________________________	_________________________
______________	________________________	_________________________

Current Medications

Please list any mediation (prescriptions and non-prescription) you are currently taking (including vitamins & aspirin)

Medications	Dosage	Number taken daily
_______________________________	____________________	_______________________
_______________________________	____________________	_______________________
_______________________________	____________________	_______________________
_______________________________	____________________	_______________________
_______________________________	____________________	_______________________
_______________________________	____________________	_______________________
_______________________________	____________________	_______________________
_______________________________	____________________	_______________________

List of Herbal medications & Vitamins:

_______________________________	____________________	_______________________
_______________________________	____________________	_______________________
_______________________________	____________________	_______________________
_______________________________	____________________	_______________________
_______________________________	____________________	_______________________

Are you taking any blood thinners? (Coumadin, Warfarin, Plavix, Aspirin, etc.) ☐ Yes ☐ No

Please list, including dosage: ____

Allergy History

Have you ever had an allergic reaction to any medication? YES ☐ NO ☐ if yes, please list medication & reaction.

____

Are you allergic to latex, x-ray dye or iodine? YES ☐ NO ☐ If yes, please explain? ________________________

Other Treatment

Please list other recent treatment for pain other medical condition. (e.g., physical therapy, acupuncture, hypnosis, psychiatric counseling,
etc.)____

____

Patient's Name: ______________________________ Date: ______________________

Social History

Birthplace: ______________________ Highest grade completed in school: ____________________

Are you currently working? **YES** ☐ **NO** ☐

Employer: ____

Occupation: ____

Who currently lives with you? ______________________________________

Have you ever smoked cigarettes? **YES** ☐ **NO** ☐

If yes, how much do you currently smoke per day? **None** ☐ **½ pack** ☐ **1 pack** ☐ **>1pack** ☐

If you previously smoked, how long ago did you quit? **<1 yr.** ☐ **1-5 yrs.** ☐ **>5 yrs.** ☐

How many years did you smoke? ________________________

Have you had significant exposure to: Pesticides? **YES** ☐ **NO** ☐ Toxic Waste? **Yes** ☐ **NO** ☐

Do you drink alcohol? **YES** ☐ **NO** ☐ Type: ___________________

How often/much do you drink alcohol? __________________________

Do you exercise? **YES** ☐ **NO** ☐

If yes how much? **Rarely** ☐ **Occasionally** ☐ **>3 times per week** ☐

Family History

(Please Circle)

Family Members		Age (or age at death):	Sex:		Living:		Medical Problems:
Grandparents –	**Paternal:**	____________	M	F	Yes	No	____________________
	Paternal:	____________	M	F	Yes	No	____________________
	Maternal:	____________	M	F	Yes	No	____________________
	Maternal:	____________	M	F	Yes	No	____________________
	Father:	____________			Yes	No	____________________
	Mother:	____________			Yes	No	____________________
	Siblings:	____________	M	F	Yes	No	____________________
		____________	M	F	Yes	No	____________________
		____________	M	F	Yes	No	____________________
		____________	M	F	Yes	No	____________________
	Children:	____________	M	F	Yes	No	____________________
		____________	M	F	Yes	No	____________________
		____________	M	F	Yes	No	____________________

PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

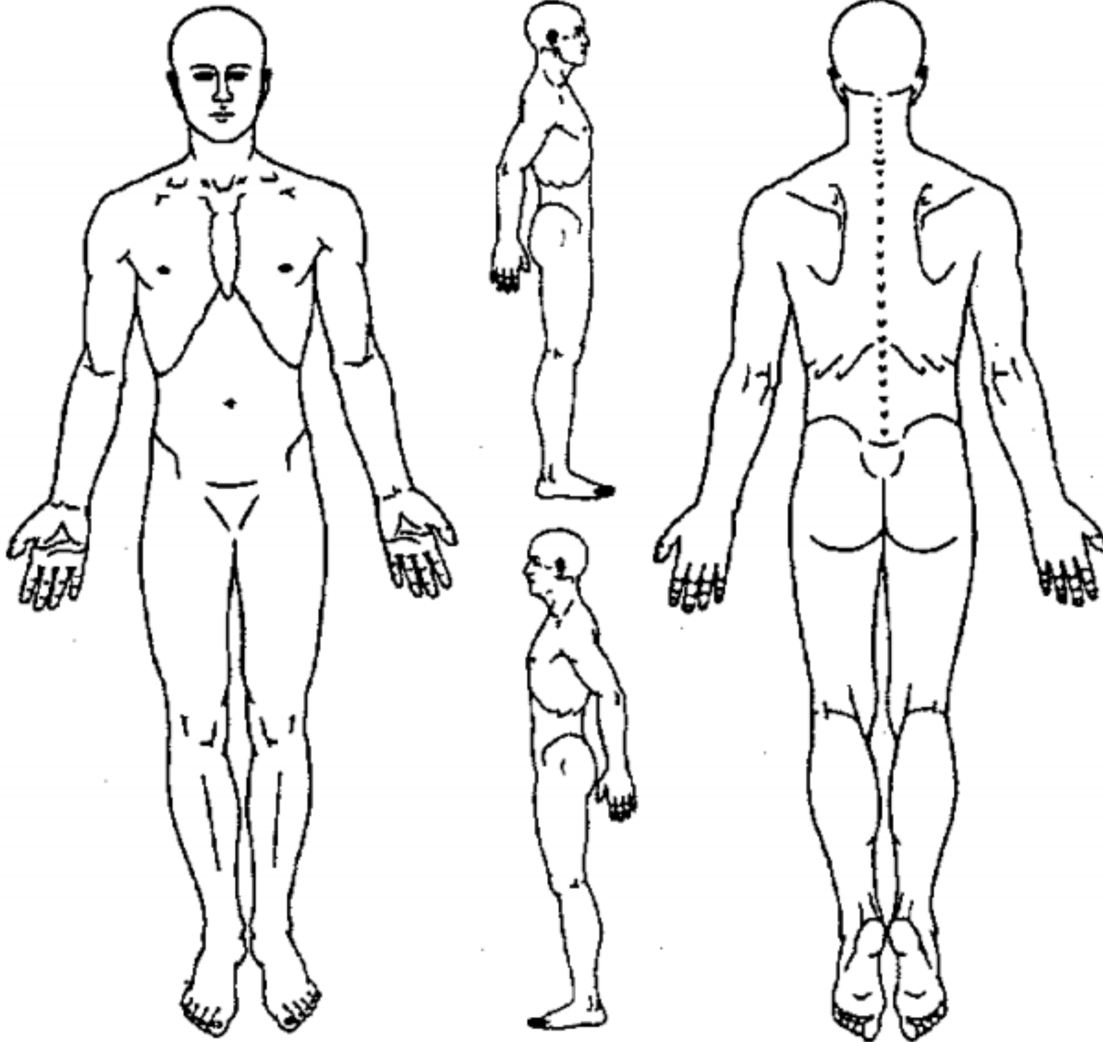
No Pain										Worst Possible Pain
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Patient's Name: ____ **Date:** __________________________

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



If **Other** please explain?

____

____

____

Review of Systems: Have you experienced any of the following symptoms? Please circle yes or no.

Symptom	Circle One
ALLERGY/IMMUNOLOGY	
Low resistance to infection	YES NO
Environmental allergies	YES NO
CARDIOVASCULAR	
Chest pain or angina	YES NO
Irregular heart rhythm	YES NO
CONSTITUTIONAL	
Recent weight change	YES NO
Good general health lately	YES NO
Recurrent fevers, chills, sweats	YES NO
Extreme fatigue	YES NO
Frequent nausea, vomiting	YES NO
Difficulty sleeping	YES NO
EARS, NOSE, MOUTH, THROAT	
Change in hearing	YES NO
Ringing in the ears	YES NO
Recent nose bleeds	YES NO
Chronic sinus problems	YES NO
Voice changes	YES NO
EYES	
Change in vision	YES NO
Glaucoma	YES NO
ENDOCRINE	
Heat or cold intolerance	YES NO
Excess thirst or urination	YES NO
GASTROINTESTINAL	
Change in appetite	YES NO
Severe heart burn	YES NO
Vomiting blood	YES NO
Frequent diarrhea	YES NO
Constipation	YES NO
Black or bloody stools	YES NO
Abdominal pain	YES NO
GENITOURINARY	
Blood in urine	YES NO
Burning with urination	YES NO
Difficult/frequent urination	YES NO
Lack of bladder control	YES NO
Sexually transmitted disease	YES NO
Change in sexual function	YES NO
HEMATOLOGICAL/LYMPHATIC	
Easy bruising	YES NO
Frequent bleeding	YES NO
Enlarged lymph nodes	YES NO
INTEGUMENTARY (SKIN & BREAST)	
Unusual or prolonged rashes	YES NO
Breast pain or lump	YES NO
Change in hair or nails	YES NO

Symptom	Circle One
MUSCULOSKELETAL	
Joint swelling	YES NO
Difficulty walking	YES NO
NEUROLOGICAL	
Headaches	YES NO
Numbness/tingling sensation	YES NO
Weakness or paralysis	YES NO
Convulsions or seizures	YES NO
Change in memory/concentration	YES NO
Loss or blurry vision/double vision	YES NO
Black outs/dizziness	YES NO
Memory loss or confusion	YES NO
Other neurological problems	YES NO
PAIN	
Joint stiffness or pain	YES NO
Muscle pain	YES NO
Neck pain	YES NO
Back pain	YES NO
Other pain (please specify)	YES NO
PSYCHIATRIC	
Nervousness	YES NO
Depression	YES NO
Other	YES NO
RESPIRATORY	
Breathing problems/shortness of breath	YES NO
Coughing up blood	YES NO
Chronic cough	YES NO

Please read this document carefully.

Premier Brain & Spine Institute requires the Terms and Conditions of Service to be signed in its entirety, without alteration.

1. **TERM OF AGREEMENT**. I understand that the terms and conditions in this outpatient agreement will remain in effect for one year from the date of signature and that I will be asked to sign this agreement annually. I understand I will be asked to confirm that my demographic and insurance information is correct at each clinic visit. If my insurance or demographics information has changed, I will inform the clinic staff.
2. **MEDICAL CONSENT.** I, the undersigned, consent to the general treatment and procedures that may be limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to the patient under the general and special instructions of the patient's physician or surgeon. I also authorized Premier Brain & Spine Institute to use and/or dispose, at its discretion, any blood, bodily fluid, member, organ, or other tissue removed or obtained during an operation, procedure or treatment, for research that maybe conducted by Premier Brain & Spine Institute or unaffiliated academic or commercial third parties if allowed under legal requirements and Premier Brain & Spine Institute policies. I understand that it is the responsibility of the patient's physician to obtain the patient's informed consent when required for specific medical or surgical treatment and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, allied health practitioners (such as physician assistants and nurse practitioners) may participate in the patient's care.
3. **PHOTOGRAPHY.** I consent to the taking of pictures, videotapes or other electronic reproductions of the patient's medical or surgical condition or treatment, and the use of the pictures, videotapes or electronic reproductions, for purposes permitted by law. Under specific circumstances, I may be asked for separate consent prior to the talking of pictures, videotapes or other electronic reproductions of the patient's medical or surgical condition or treatment and the use of those pictures, videotapes or electronic reproductions. If the image could be directly used to identify the patient, I will be asked for authorization to use or disclose the image, unless it is for treatment, internal teaching activities, institutionally approved research in specific cases, or limited other activities consistent with applicable privacy laws.
4. **FINANCIAL AGREEMENT.** For the services to be rendered, I agree to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of Premier Brain & Spine Institute. This includes financial responsibility for all deductibles and co-payment that may be required by the patient's insurance or health plan, including Medicare and Medi-Cal. Should the patient's account(s) be referred to an attorney or a collection agency for collection. I further agree to pay actual attorneys' fees and lawsuit-related expenses incurred in addition to other amounts due. When the services are to be billed to insurance, a health plan or another payment source, paragraph 5 (Contracted Health Plan Patients and Other Sources) and/or 6 (Assignment of Insurance Benefits will also apply).
5. **CONTRACTED HEALTH PLAN PATIENTS AND OTHER SOURCES.** I understand that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which Premier Brain & Spine Institute contracts, or through some other source (e.g., clinical trial sponsor, employer's worker's compensation insurance). I agree to be responsible under paragraph 4 contract with the health plan; (b) for any co-payment and deductible; (c) for services not approved by the health plan or other source; (d) for services not covered and/or paid by the patient's health plan or other source to the extent allowed by law or contract.
6. **ASIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS).** I authorize direct payment to Premier Brain & Spine Institute of any insurance benefits otherwise payable to or on behalf of the patient for outpatient services at a rate not to exceed the actual institutional and professional charges. I understand and agree that I am financially responsible under paragraph 4 (Financial Agreement) for charges not paid in accordance with this assignment. If applicable, I further attest that information given to Premier Brain & Spine Institute to assist the patient in applying for payment under Medicare or Medi-Cal is correct.

The undersigned certifies that he/she has read both pages of the Terms and Conditions of Services, has received a copy of it, and is the patient or is duly authorized by or on behalf of the patient to execute and accept its terms.

___________________________________	___________________________________	____________________
Patient or Responsible Person Signature	Print Name	Date/Time

Please indicate relationship of person signing this document:

☐ Patient Authorized Consent ☐ Patient with Legal Custody ☐ Legal Guardian/Temporary Legal Guardian

Explain type of guardianship: ____

- ☐ Person with written Authorization (e.g. Caregiver's Authorization Affidavit, Third Party Authorization, Durable Power of Attorney)
- ☐ Explain type of written authorization: ____
- ☐ Documentation of written authorization received

If interpreted: ___________________________ ______________________________ ___________________

Interpreter Signature Print Name Language

____ ____________________________

Position/Relationship to patient Date/Time

FINANCIAL RESPONSIBITIES AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTITIVE

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the paragraphs on Financial Agreement (4) and, if applicable, Contracted Health Plan and Other Sources (5) and Assignment of Insurance Benefits (6) above.

____	_____________________________	____________________
Financial Responsible Party	Relationship to Patient	Date/Time