Palm Beach Neurosurgery, LLC

Specializing in Surgical Diseases of the Brain, Spine and Nerves

PATIENT REGISTRATION & INFORMATION
PLEASE PRINT

Name: _____
Last First Middle

Date of Birth: _____ SS#: _____ Marital Status: _____

Gender: _____ Language: _____ Race: _____ Ethnicity: Hispanic/Non-Hispanic/Other

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell#: _____ Work #_____

Emergency Contact name & #: _____

Your Email Address: _____

Primary Dr: _____ Phone #:_____
First Last

Referring Dr: _____ Phone #: _____
First Last

Is this visit due to an Auto Accident? _____ Work Injury? _____ Slip or fall? _____

Second Opinion? _____ Do you have a Legal Case Pending? _____ Due to? _____

Pharmacy Name: _____ Phone#: _____

_____ _____
Patient (or Responsible Party) Signature Date

Tel. 561-433-4444

3319 State Road 7
Suite #313
Wellington, FL 33449

601 University Blvd.
Suite #203
Jupiter, FL 33458

Fax. 561-433-8877

www.pbneurosurgery.com

Patient Name: _____ Date: _____

Main Complaint for your visit today: _____
_____

When did this problem start? _____

Are you: Left handed or Right handed (circle one) Are you allergic to contrast dye? _____

Medication Allergies: _____

Food Allergies: _____

ALL CURRENT MEDICATIONS:_____
_____
_____
_____

Immediate Family History:
Father - Alive and Well_____ Alive with Problems_____ Deceased_____
Mother- Alive and Well_____ Alive with Problems_____ Deceased_____

Sibling (Brother/Sister) - Alive and Well_____ Alive with Problems_____ Deceased_____
Sibling (Brother/Sister) - Alive and Well_____ Alive with Problems_____ Deceased_____

Past medical history:

Anemia	yes	no	unknown	Bladder Infection	yes	no	unknown
Cancer	yes	no	unknown	Urinary Infection	yes	no	unknown
Diabetes	yes	no	unknown	Kidney Stones	yes	no	unknown
Gout	yes	no	unknown	STD's	yes	no	unknown
High Cholesterol	yes	no	unknown	Hemorrhoids	yes	no	unknown
Hypertension	yes	no	unknown	B Prostatic Hypertorphy	yes	no	unknown
Aids	yes	no	unknown	Arthritis Osteo	yes	no	unknown
Cataracts	yes	no	unknown	Arthritis Rheumatoid	yes	no	unknown
Glaucoma	yes	no	unknown	Seizure Disorder	yes	no	unknown
Hearing impaired	yes	no	unknown	Headache Migraine	yes	no	unknown
Thyroid Disease	yes	no	unknown	Headache Tension	yes	no	unknown
Asthma	yes	no	unknown	Headache Other	yes	no	unknown
COPD	yes	no	unknown	Alcohol Depend.	yes	no	unknown
Pneumonia	yes	no	unknown	Drug Depend.	yes	no	unknown
Tuberculosis	yes	no	unknown	Depression	yes	no	unknown
Myocardial infart.	yes	no	unknown	Alzheimers	yes	no	unknown
Arthr. Heart Disease	yes	no	unknown	Cerebrovascular disease	yes	no	unknown
Cong. Heart Failure	yes	no	unknown	Hydrocephalus	yes	no	unknown
Arrhythmias	yes	no	unknown	Stroke	yes	no	unknown
Peptic Ulcer	yes	no	unknown	Eye Problems	yes	no	unknown
Gall Stones	yes	no	unknown	Concussion	yes	no	unknown
Cirrhosis	yes	no	unknown	Meningitis	yes	no	unknown
Hepatitis	yes	no	unknown	Psychiatric disorder	yes	no	unknown
Sleep Apnea	yes	no	unknown	Fibromyalgia	yes	no	unknown

Any we did not list? _____
_____

Patient Name _____ Date _____

Pregnant yes no Irregular Periods yes no
Menopause yes no

Other Illness _____
_____

ALL Past Surgeries and dates: _____
_____

Are you on any blood thinners (medications)? _____
Do you have any Metal or Implants in your body? _____
Previous treatment Brain or Spine and Dates: _____
_____
Epidurals _____
Physical Therapy _____
MRI (location and date) _____
CT SCAN/X-RAYS (location and date) _____
Do you smoke: ◯ yes ◯ no how many packs a day _____
Do you drink: ◯ yes ◯ no how much and how often _____

FAMILY HISTORY – your blood relatives have had the following:

TB (Tuberculosis)	◯ yes	◯ no	Stroke	◯ yes	◯ no
High blood pressure	◯ yes	◯ no	Diabetes yes	◯ yes	◯ no
Epilepsy (seizures)	◯ yes	◯ no	Cancer	◯ yes	◯ no
Heart problems	◯ yes	◯ no			

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

Shortness of breath	◯ yes	◯ no	Chest pain	◯ yes	◯ no
Blood in stool	◯ yes	◯ no	Numbness	◯ yes	◯ no
Blood in urine	◯ yes	◯ no	Headaches	◯ yes	◯ no
Uncontrolled bladder	◯ yes	◯ no	Nausea	◯ yes	◯ no
Uncontrolled bowel	◯ yes	◯ no	Tingling yes	◯ yes	◯ no
Yellow jaundice	◯ yes	◯ no	Vomiting	◯ yes	◯ no
Ringing in ears	◯ yes	◯ no	Weakness	◯ yes	◯ no
Double vision	◯ yes	◯ no	Paralysis	◯ yes	◯ no
Blurred vision	◯ yes	◯ no	Weight loss	◯ yes	◯ no
Hearing loss	◯ yes	◯ no	Weight gain	◯ yes	◯ no

PHARMACY INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____

Pharmacy Name: _____

Pharmacy Phone #: _____

Pharmacy Address or Cross Streets: _____

_____

_____

INSURANCE INFORMATION:

PRIMARY INSURANCE

Name of Insured: _____ Relationship to Insured: _____

Insurance Company: _____

Insurance Member ID #: _____ Group #: _____

Effective Date of Coverage: _____ Co-pay $: _____

SECONDARY INSURANCE- F.Y.I. WE DO NOT FILE THE SECONDARY INS.

Name of Insured: _____ Relationship to Insured: _____

Insurance Company: _____

Insurance Member ID #: _____ Group #: _____

Effective Date of Coverage: _____ Co-pay $: _____

TERTIARY INSURANCE

Name of Insured: _____ Relationship to Insured: _____

Insurance Company: _____

Insurance Member ID #: _____ Group #: _____

Effective Date of Coverage: _____ Co-pay $: _____

I AGREE THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____

Patient (or Responsible Party) Signature Date

PATIENT RESPONSIBILITIES:

** To inform office of any changes in insurance coverage

** To inform office of any changes to address or phone number

** To inform office if your visit is related to an auto accident or job related injury.

** **If you have HMO insurance, IT IS YOUR RESPONSIBILITY to provide us with a current and appropriate referral from your Primary Care Physician at the time of your visit. _____** (initials)

** If your insurance requires a referral and you are seen without a valid referral, you understand that you will be responsible for any costs incurred for the visit.

** To pay any applicable co-pays or balances due on the day of your visit.

** To provide the Doctor with any diagnostic films or disks he requests: Note: when you have a diagnostic test (such as MRI, X-RAY, CT SCAN) it is **YOUR RESPONSIBILITY** to bring your films or disks along with the reports to your next visit. **YOUR FILMS OR DISKS ARE NOT DELIVERED TO US NO MATTER WHAT THEY TELL YOU!!!! _____** (initials)

** I understand there is a $ 25.00 fee for any and all forms that may need to be filled out by the Doctor/staff on my behalf.

I, the patient, have read and understand the above responsibilities:

Signature: _____ Date: _____

Patient Consent Form
Please read and sign.

I, the undersigned, hereby consent to the following treatment:

- **Administration and performances of all treatments**
- **Administration of any needs anesthetics**
- **Performance of such procedures as may be necessary or advisable in the treatment of this patient**
- **Use of prescribed medications**
- **Performance of diagnostic procedures/tests and cultures**
- **Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.**

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand the Palm Beach Neurosurgery, LLC may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Drs. Dutcher, Abdolvahabi, Cantando, and Schlifka will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practiced.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or it's intermediaries for my Medicare claims. I assign the benefits payable for services to Palm Beach Neurosurgery, LLC/ Drs. Dutcher, Abdolvahabi, Cantando, or Schlifka

I acknowledge that I have been given a copy of the Palm Beach Neurosurgery, LLC Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initials: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature **Date**

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Palm Beach Neurosurgery, LLC is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you Approve to receive information	**Description of Information to be released** Check each that can be given to person/entity
☐ Voice Mail	☐ Results of Labs/Imaging ☐ Other:
☐ Spouse (Name & phone #) __	☐ Financial ☐ Medical as follows:
☐ Parent (Name & phone #)	☐ Financial ☐ Medical as follows:
☐ Other (Name & #)	☐ Financial ☐ Medical as follows:

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)