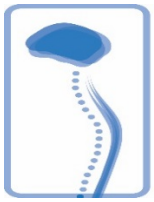

# NEUROLOGICAL SURGERY
## ASSOCIATES P.C.

513 Brookwood Blvd, Suite 372
Birmingham, AL 35209

Phone: (205) 949-1800
Fax: (205) 870-7735

**PATIENT INFORMATION**

Patient Name:_____

Date of Birth: _____ Age: _____ Sex: M F Marital Status: _____

SS#: _____ Preferred Language: _____

Race: __ African American __ American Indian __ Asian __ Caucasian __ Other _____

Ethnicity: _____ Hispanic/Latino _____ Non Hispanic/Latino

Phone: Primary: _____ Secondary: _____

Address/City/State/Zip:_____

Email: _____

Employer: _____

Emergency Contact: _____ Phone: _____

Who referred you to our physician? _____

Who is your primary care doctor? _____

Phone: _____

**Would you like your primary care doctor/referring doctor (circle one or both) to receive a copy of your treatment records by our physician? If no, check here: _____**

Primary Insurance: _____

Policy # _____ Group # _____

Who is the insured: _____

Relationship to patient: _____ Date of birth: _____

Secondary Insurance: _____

Policy # _____ Group # _____

Who is the insured: _____

Relationship to patient: _____ Date of birth: _____

NAME:_____ AGE:_____DATE:_____

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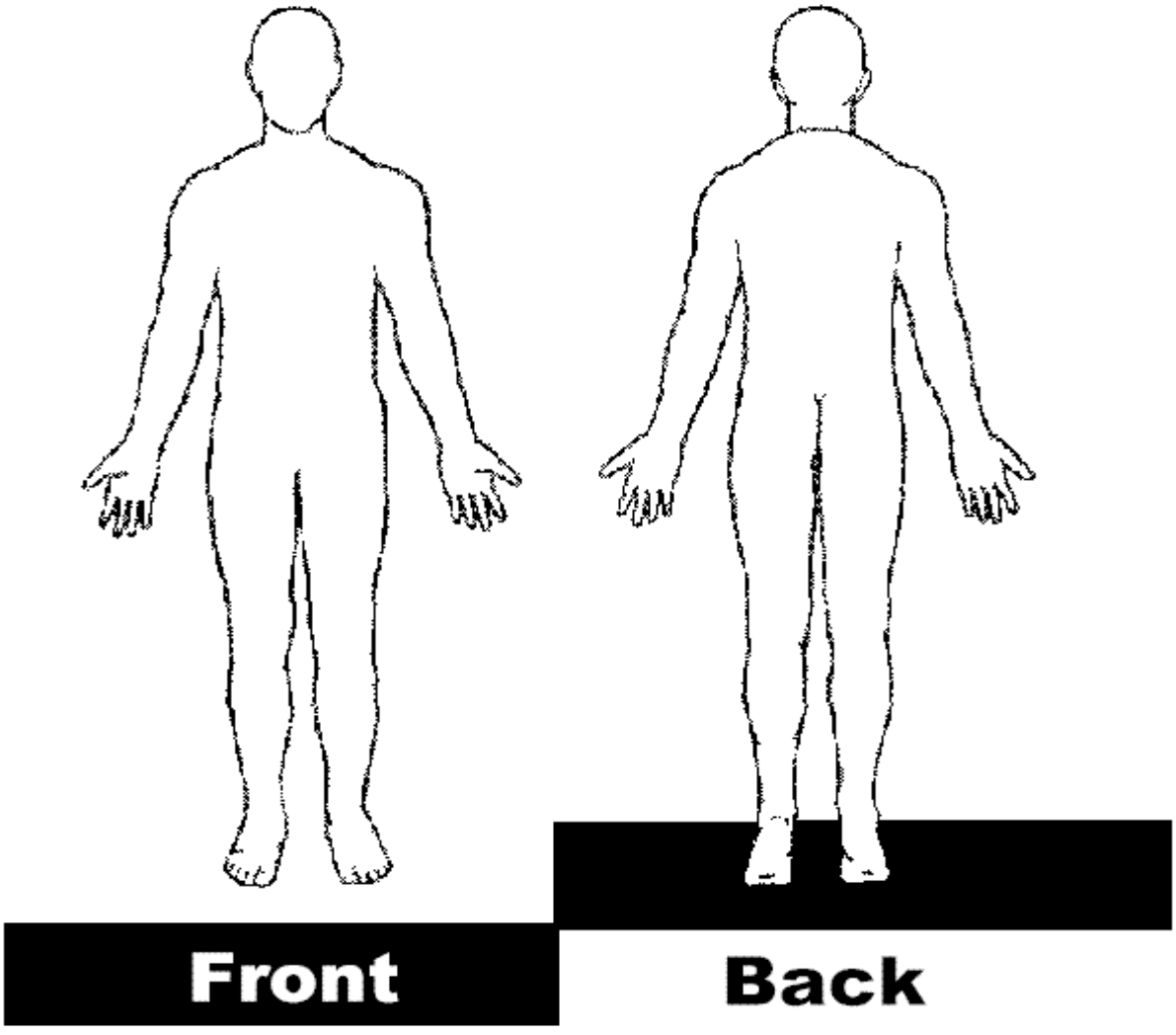
# PATIENT PAIN DRAWING

Using the symbols given below, mark the areas on your body where you feel the described sensation. Include all affected areas.

| Other | Aching | Numbness | Pins & Needles | Burning | Stabbing |
|---|---|---|---|---|---|
| 0000 | ▲▲▲ | ==== | ++++ | xxxx | ///// |




NAME:_____ AGE:_____DATE:_____

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What is your primary complaint?_____

When did your symptoms begin?_____

Did you injure yourself at work? _____ Date of injury:_____

Are you currently working?_____ Full-duty _____ Light-duty_____

How did you get injured?_____

Have you had previous back or neck problems?_____ Describe_____

_____

What makes it worse?_____

What makes it better?_____

Does coughing or sneezing make it worse? _____ Any change in bowel or bladder habits?_____

Which is worse, back pain or neck pain?_____ Which is worse, back pain or leg pain?_____

Which is worse, leg pain or arm pain?_____ Which is worse, neck pain or arm pain?_____

Which is worse, left arm or right arm?_____ Which is worse, left leg or right leg?_____

Do you have leg weakness? _____ If yes, which leg?_____

Do you have leg numbness?_____ If yes, which leg?_____

Do you have arm weakness?_____ If yes, which arm?_____

Do you have arm numbness?_____ If yes, which arm?_____

Have you ever had an epidural block or steroid injection for pain? _____

For what part of the body?_____ How many blocks have you received?_____

When did you receive them? _____

Name of MD who performed blocks_____

How long did you get relief from the block?_____

Have you ever seen a Chiropractor?_____ If yes, who and when?_____

Have you undergone any physical therapy?_____ If yes, please circle which treatments you received

TENS UNIT HEAT ULTRASOUND POOL THERAPY EXERCISE TRACTION MASSAGE

What are the dates you participated in physical therapy?_____

NAME:_____ AGE:_____DATE:_____

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What is your height?_____ Weight? _____

Please list any allergies you have, or specify none: _____

What reaction does each medication allergy cause:_____

_____

Are you in a medication management clinic with another physician?_____ Where?_____

Do you receive medications from another doctor?_____ What doctor?_____

Do you drink alcohol? _____ How much? _____ Tobacco use?_____ How much?_____

Please list all current medications (name and dose):_____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Have you ever had any previous back or neck surgery?_____ If yes, please list with date:_____

_____

_____

Please list any other major surgeries with dates: _____

_____ _____

_____ _____

_____ _____

PLEASE LIST ANY MAJOR COMPLICATION AFTER ANY MAJOR SURGERY PERFORMED IN THE PAST. (i.e. infections, blood clots, lung disorders, nerve damage, bleeding disorders, anesthesia, sexual dysfunctions.)

_____

Please list all past and present medical problems: (ex: hypertension, diabetes, high cholesterol, etc.)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Signature of patient:_____ Date:_____

NAME:_____ AGE:_____DATE:_____

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ASSOCIATES P.C.

**The following people have my permission to obtain or have discussed with them my Protected Health Information (PHI):**

NAME: _____ Relationship to patient: _____

NAME: _____ Relationship to patient: _____

NAME: _____ Relationship to patient: _____

**The following people have my permission to verify that I am at, or have been at, my doctor visit or treatment:**

NAME: _____ Relationship to patient: _____

NAME: _____ Relationship to patient: _____

_____ I do not wish to list anyone. I do not want any information to be released.

**Authorization to leave messages on answering machines/voice mail**

I, the undersigned, authorize Neurological Surgery Associates, P.C. to leave messages containing medical information, test results, doctor's recommendations on an answering machine/voice mail at the following phone number(s): _____

**Assignment and release**

I, the undersigned, authorize my insurance carrier/worker's compensation carrier to pay benefits directly to Neurological Surgery Associates, P.C. and furthermore authorize the release of any and all information required to process my claim. I understand I am responsible for all non-covered services, deductibles, and copays. In the event of a nonpayment or denial of payment by my insurance carrier/worker's compensation carrier, I agree to pay all costs of services and collections, including reasonable attorney's fees, as well as the legal interest on the account until paid in full.

**Notice of Privacy Practices**

I, the undersigned, have received a copy of Neurological Surgery Associates' Notice of Privacy Practices.

Signature: _____ Date of birth: _____

NAME:_____ AGE:_____DATE:_____

NEUROLOGICAL SURGERY
ASSOCIATES P.C.

## Consent for HIV (AIDS) Screening

HIV screening and hepatitis profile may be done on patients who must be hospitalized for surgery. This screening will not be done until pre-admission testing for surgery. This information is confidential and may not be released to anyone without specific written consent.

I, the undersigned, hereby authorize Neurological Surgery Associates, P.C. to test me for the following:

1) HIV (AIDS) virus
2) Hepatitis

I understand that if either of these tests are positive, the staff of Neurological Surgery Associates, P.C. are authorized to report these findings to the following, and by signing this consent give my permission to release information to:

1) The State Health Department
2) Healthcare workers involved in my care

Signature: _____Date of birth: _____

** Please note that Dr. Swaid has an interest in American Health Imaging, Vestavia Hills. Dr. Swaid or Dr. Jones may order an MRI for you and refer you to American Health Imaging, Vestavia Hills. If you would like to have your service at another location, we would be happy to coordinate with another MRI facility. As always, patients have the choice to obtain medical services elsewhere and will not be treated differently if they decide to do so.

NAME:_____ AGE:_____DATE:_____