Austin Brain & Spine

Patient Information (Please Print)

❑ Dr. ❑ Miss ❑ Mr. ❑ Mrs. ❑ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address _____

Date of Birth MM_____ /DD _____ /YYYY _____ Sex ❑ F-Female ❑ M-Male ❑ Transgender

Race ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Pacific Islander ❑ Black or African American ❑ White ❑ Declined Ethnicity
❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined

Language ❑ English ❑ Spanish ❑ Indian ❑ Japanese ❑ Chinese ❑ Korean ❑ French ❑ German ❑ Russian ❑ Other _____

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Social Security Number _____- _____- _____ Employer Name _____

Employment Status ❑ 1 - Full-Time ❑ 2 - Part-Time ❑ 3 - Not Employed ❑ 4 - Self-Employed ❑ 5 - Retired ❑ 6 - Active Military Student Status
❑ F - Full-Time Student ❑ P - Part-Time Student ❑ N - Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ❑ Yes ❑ No

Emergency Contact Relationship to Patient _____ ❑ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Preferred Pharmacy _____

Responsible Party Information (Information used for patient balance statements)

Responsible Party ❑ Another Patient ❑ Guarantor ❑ Self Check here if information is same as patient ❑

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____ /DD ___ /YYYY _____

Social Security Number _____- _____- _____ Telephone _____

E-Mail Address _____ Sex ❑ F-Female ❑ M-Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

Primary Insurance Information (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount_____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

Secondary Insurance Information (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____

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Medical History

History of present illness - Please briefly describe why you are here and how long you have beene0periencing your current symptoms:

Review of symptoms (check all that apply) :

1. General
   - __ weight loss
   - __ weight gain
   - __ fever

2. HENNA
   - __ blurry vision
   - __ double vision
   - __ nosebleeds
   - __ hoarseness
   - __ loss of smell
   - __ ringing in ears

3. Pulmonary
   - __ shortness of breath
   - __ coughing blood

4. Cardiovascular
   - __ chest pain
   - __ irregular heartbeat
   - __ ankle swelling

5. Gastrointestinal
   - __ heartburn
   - __ nausea/vomiting
   - __ rectal bleeding
   - __ incontinence

6. Genito-Urinary
   - __ incontinence
   - __ frequent urination
   - __ blood in urine
   - __ painful urination

7. Neuro
   - __ headaches
   - __ seizures
   - __ weakness
   - __ visual changes

8. Endocrine
   - __ cold intolerance
   - __ hair loss
   - __ impotence

9. Integ
   - __ acne
   - __ skin color change
   - __ pruritus

10. Women Only: Last menstrual period _____
    - __ breast discharge

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801 W. 38th Street, Suite 400
Austin, TX 78705

4101 James Casey Street, Suite 340
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512-306-1323

512-306-1142 fax

www.austinbrainandspine.com

Matthew Hummell, MD; Craig Kemper, MD, FACS; Marcella Madera, MD; Daniel Peterson, MD, FACS; Hari Tumu, MD

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Past Medical History

___ asthma _____

___heart disease _____

___lung disease _____

___kidney disease _____

___diabetes _____

___bleeding problems _____

___high blood pressure _____

___ AIDS/HIV _____

___ liver disease _____

___high cholesterol _____

___other (accidents, etc.) _____

Past Surgical History

	Procedure	Doctor	Date
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

Family History

Condition	Relative
___ heart disease	_____
___cancer (location and type)	_____
___ diabetes	_____
___high blood pressure	_____
___ tuberculosis	_____
___migraines	_____
___stroke	_____

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Current Medications

	Medicine	Dosage	Frequency
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____

Allergies

1 _____

2 _____

3 _____

None Known _____

Current Height: _____

Current Weight: _____

Social History

Occupation

Tobacco _____ none

_____ previously ___ # of years _____ packs per day _____ date quit

_____ currently ____ # of years _____ packs per day

Alcohol _____ drinks per week

Illicit Drug Use _____

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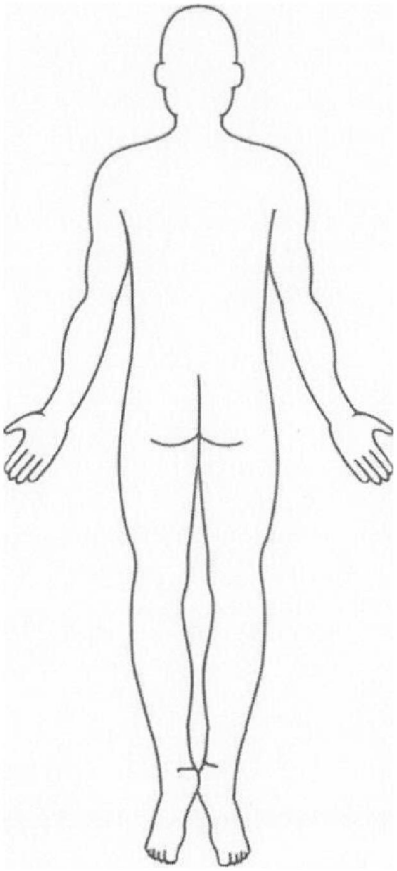
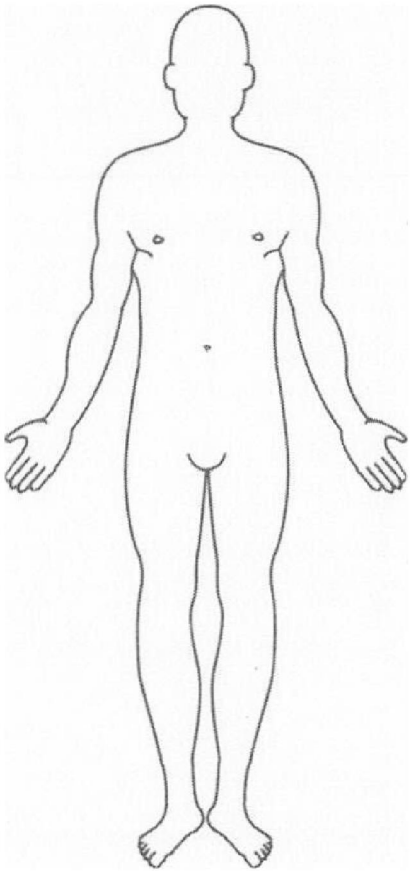
Name _____ Date _____

Mark these drawings according to where you hurt (if the back of your neck, mark the drawing on the back of the neck, etc). If you feel any of the following symptoms, please indicate where you feel them by placing the appropriate marks on the diagrams. Include all affected areas.



Numbness
11111
Pins and Needles
000000
Burning
######
Stabbing
/////
Ache
*****



1. How bad is your pain now?

2. Please mark with an x on the body form where the pain is worst now.

3. Please circle the appropriate number below representing how bad your pain is now.

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

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