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 _____

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____ (Patient or Guardian Initials)

   Financial Agreement.
   - I acknowledge that, as a courtesy, AUSTIN BRAIN AND SPINE may bill my insurance company for services provided to me.
   - I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
   - I understand that there is a fee for returned checks.

2. _____ (Patient or Guardian Initials)

   Third Party Collection. I acknowledge that AUSTIN BRAIN AND SPINE may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____ (Patient or Guardian Initials)

   Assignment of Benefits. I hereby assign to AUSTIN BRAIN AND SPINE any insurance or other third-party benefits available for health care services provided to me. I understand AUSTIN BRAIN AND SPINE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to AUSTIN BRAIN AND SPINE, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____ (Patient or Guardian Initials)

   Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to AUSTIN BRAIN AND SPINE by the Medicare or Medicaid program.

5. _____ (Patient or Guardian Initials)

   Consent to Telephone Calls for Financial Communications. I agree that, in order for AUSTIN BRAIN AND SPINE, or Extended Business Office (EBO) Services and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that AUSTIN BRAIN AND SPINE or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or AUSTIN BRAIN AND SPINE or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ (Patient or Guardian Initials)

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

Patient/Patient Representative Signature:

X _____ Date _____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below:

☐ Spouse
☐ Parent
☐ Legal Guardian
☐ Guarantor
☐ Healthcare Power of Attorney
☐ Other (please specify)

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

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

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	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
   - __ incontinence

5. Gastrointestinal
   - __ heartburn
   - __ nausea/vomiting
   - __ rectal bleeding
   - __ painful urination

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

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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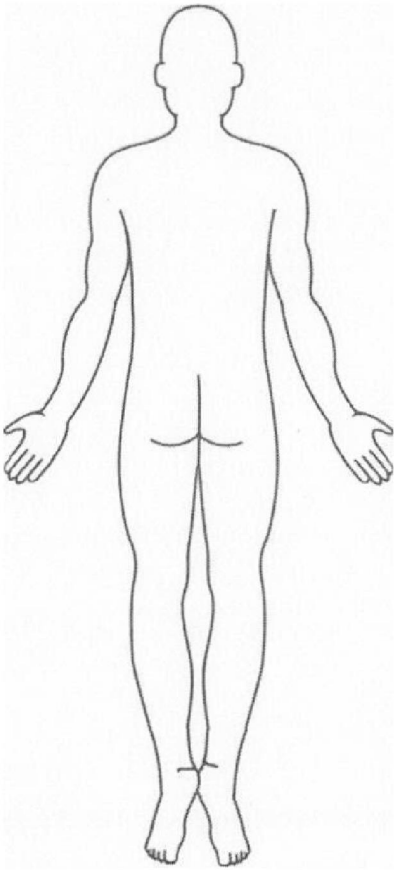
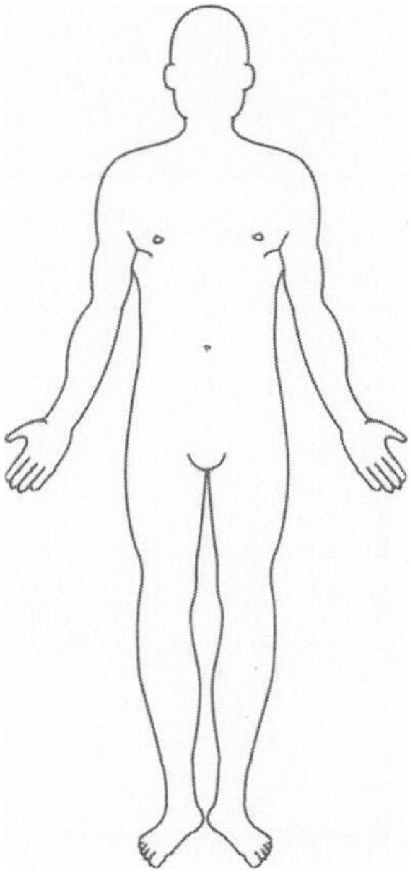
Name _____ Date _____

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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