Austin Brain & Spine

PATIENT INFORMATION • PLEASE PRINT

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

Previous Name _____

Date of Birth MM_____ /DD _____ /YYYY_____

Gender Identity ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female

☐ Genderqueer ☐ Choose not to disclose ☐ Additional Gender category not listed _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell No. _____

Work Phone _____ Ext. _____

E-Mail Address _____

Primary Care Provider (PCP) _____

Referring Provider _____

RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ Black or African American ☐ White ☐ Declined

ETHINICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

LANGUAGE ☐ English ☐ Spanish ☐ ASL ☐ Other _____

MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____- _____- _____

Employer Name _____ **Job Title** _____

EMERGENCY CONTACT

Last Name _____ First Name _____

Cel No. _____ Home Phone _____

Work Phone _____ Ext. _____

Do you have a living will? ☐ Yes ☐ No

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PREFERRED PHARMACY

Pharmacy Name _____

Address _____

Phone _____

☐ **SELF PAY** ☐ **BILL INSURANCE** *(info below)*

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 these forms 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 been experiencing 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. Musculoskeletal
- ☐ back pain
- ☐ muscle pain
- ☐ neck pain
- ☐ injury
- ☐ weakness
- ☐ numbness

ALLERGIES

DRUG/FOOD/LATEX

1 _____

2 _____

3 _____

☐ None Known

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

(512) 306-1323 | FAX (512) 306-1142 | www.austinbrainandspine.com

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LA GRANGE Two Saint Mark's Place | Suite 160 | La Grange, TX 78945

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CURRENT MEDICATIONS

	MEDICINE / ANTICOAGULANTS	STRENGTH	FREQUENCY
1			
2			
3			
4			
5			
6			
7			
8			

PAST MEDICAL HISTORY

- ☐ asthma _____
- ☐ heart disease _____
- ☐ lung disease _____
- ☐ kidney disease _____
- ☐ diabetes _____
- ☐ bleeding problems _____
- ☐ high blood pressure _____
- ☐ AIDS/HIV _____
- ☐ liver disease _____
- ☐ high cholesterol _____
- ☐ stroke _____
- ☐ migraines _____
- ☐ cancer _____
- ☐ other (accidents, etc.) _____

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PAST SURGICAL HISTORY

	PROCEDURE	DOCTOR	DATE
1			
2			
3			
4			

FAMILY HISTORY

CONDITION	RELATIVE	LIVING / NON-LIVING
☐ heart disease		☐ living / ☐ non-living
☐ cancer *(location & type)*		☐ living / ☐ non-living
☐ diabetes		☐ living / ☐ non-living
☐ high blood pressure		☐ living / ☐ non-living
☐ tuberculosis		☐ living / ☐ non-living
☐ migraines		☐ living / ☐ non-living
☐ stroke		☐ living / ☐ non-living

IMAGING

Do you have a preferred imaging facility? _____

Do you have metal in your body? _____

Do you require sedation? _____

SOCIAL HISTORY

Tobacco/Smokeless Tobacco

☐ none ☐ previously: _____ # of years _____ packs per day. date quit: _____

☐ currently: _____ # of years _____ packs per day

Alcohol ☐ none ☐ _____ drinks per week

Illicit Drug Use _____

FALLS

Have you had any falls in the last ☐ 3 months ☐ 12 months

With injury? ☐ yes ☐ no

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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 tests) 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: