COMPREHENSIVE SPINE CENTER

NEUROSURGERY ORTHOPEDICS

GLOBAL NEUROSCIENCES INSTITUTE | Redeemer Health

NEW PATIENT REGISTRATION FORM

PATIENT'S LEGAL NAME:

Last:_____ First:_____ Middle:_____

Mailing Address:_____ Email:_____

Preferred Contact # ☐ Home Phone #:_____ ☐ Cell Phone #:_____

Birth Date: / / Age:_____ Gender:_____

Social Security #:_____

Patient's Employer:_____ Employer Phone #:_____

We are now required to collect Race, Ethnicity and preferred language. You may choose "Prefer not to answer".

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Prefer not to answer
- ☐ Other
- ☐ White

Ethnicity:

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Prefer not to answer

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Prefer not to answer
- ☐ Other _____

INSURED'S EMPLOYER:

Company Name: _____ Occupation: _____

Company Address:_____

Years Employed:_____ Employer Phone #:_____

Spouse/Parent ***(person to be billed if patient is under age 18)***

Name:_____ Birth Date: / / SSN:_____

Employer Name:_____ Address:_____

Phone:_____ Occupation:_____

PRIMARY INSURANCE Name: _____ Phone #:_____

Subscriber Name: _____ Member ID#:_____Group #:_____

Effective Date: / / Relationship to Insured:_____ Subscriber DOB: / /

Is this health insurance a benefit of employment? Y / N

SECONDARY INSURANCE Name: _____ Phone #:_____

Subscriber Name: _____ Member ID#:_____Group #:_____

Relationship to Insured:_____ Subscriber DOB: / /

REFERRING PHYSICIAN:

Physician Name: _____ Phone #:_____

PRIMARY PHYSICIAN:

Physician Name: _____ Phone #:_____

PHARMACY:

Pharmacy Name: _____ Phone #:_____

Address: _____

EMERGENCY & RECORDS CONTACT:

Emergency Contact: _____ Phone #: _____

Relationship:_____

Authorized Contacts for Release of Information

Authorized Contact 1: _____ Relationship: _____

Authorized Contact 2: _____ Relationship: _____

Information Only to be released to "Authorized Contact" listed above.

_____ Medical Information (Health diagnosis, treatment, etc.)

_____ Financial Information (Balance, payment, insurance)

_____ Prescription Pick up

_____ Documentation Pick up

May we leave a voicemail containing medical/personal information?

Yes No

PATIENT SIGNATURE:

Print Name: _____

Sign: _____ Date: _____

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PATIENT HEALTH HISTORY FORM

Please provide the following confidential information regarding your medical history. Thank you.

Name: _____ DOB: _____

Reason for Appointment:_____

MEDICAL HISTORY

Do you take any medications?	YES NO	Name Dosage Strength Route
Are you allergic to any medications or have any allergies?	YES NO (if yes, explain)	List:
Do you smoke or chew tobacco?	YES NO	How much per day? For how many years?
Do you drink alcohol?	YES NO	How much? How often?
Do you take aspirin?	YES NO	How much? How often?
Do you use non-prescription drugs?	YES NO	How much? How often?
Do you bleed or bruise easily?	YES NO	
Have you ever been hospitalized?	YES NO	List:
Have you had any previous surgery?	YES NO	List with dates:
Are you pregnant?	YES NO	
Are there any illnesses that run in the family?	YES NO	List:

ADDITIONAL QUESTIONS:

Is this a work related injury? YES NO

Are you right or left hand dominant? RIGHT LEFT

Do you have pain/numbness/weakness? YES NO

How long have you been dealing with this problem?

Weeks: _____ Months:_____ Years: _____

Have you had prior treatment for this problem? YES NO

Please describe treatment information: _____

Name: _____ DOB: _____

Do you have any of the following medical problems? If YES, please explain.

Heart disease	YES	NO	
High blood pressure	YES	NO	
Diabetes	YES	NO	
Thyroid problems	YES	NO	
High cholesterol	YES	NO	
Rheumatic fever	YES	NO	
Heart murmurs	YES	NO	
Stomach problems	YES	NO	
Liver problems or Hepatitis	YES	NO	
Respiratory problems	YES	NO	
Arthritis	YES	NO	
Seizures or epilepsy	YES	NO	
Blood Disorders	YES	NO	
Cancer	YES	NO	
Other	YES	NO	

Do you have any of the following symptoms now?

	YES	NO		YES	NO
Fever	_____	_____	Shortness of breath	_____	_____
Weight loss	_____	_____	Chest pain	_____	_____
Fatigue	_____	_____	Abdominal pain	_____	_____
Visual disturbance	_____	_____	Pain upon urination	_____	_____
Hearing loss	_____	_____	Muscle or joint pain	_____	_____
Nasal congestion	_____	_____	Rash	_____	_____
Sore throat	_____	_____	Weakness	_____	_____
Hoarseness	_____	_____	Numbness	_____	_____
Cough	_____	_____	Seasonal allergies	_____	_____

What is your present occupation? _____

I certify that the above information is complete and accurate.

Patient's signature: _____ Date: _____

I certify that I have reviewed the above information with the patient.

Physicians signature: _____ Date: _____