

## PATIENT HISTORY

Name \_\_\_\_\_ Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Who requested that you see our physicians? \_\_\_\_\_ Address \_\_\_\_\_

Internist or Family Physician: \_\_\_\_\_ Address \_\_\_\_\_

What is your major problem or complaint? \_\_\_\_\_

When did your problem start? \_\_\_\_\_

Was there a specific injury? \_\_\_\_\_ If so, what happened? \_\_\_\_\_

Do you consider it work related? \_\_\_\_\_ How? \_\_\_\_\_

Have you seen other doctors for this problem? \_\_\_\_\_ Who? \_\_\_\_\_

### PAST MEDICAL HISTORY (check all present):

Diabetes	Heart trouble	Stroke	Arthritis/gout	Convulsions
Hypertension	Cancer	Serious infection	Blood clots	Hereditary defects
Hepatitis/liver disease	AIDS or HIV	Psychiatric illness	Ulcer/stomach prob.	Trauma
Thyroid disease	Kidney disease	COPD/asthma	Head injury	Anemia
Other (explain) _____				

Previous surgeries (include year): 1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_ 5) \_\_\_\_\_

### Systems review (check all present):

Rash/unusual mole	Easy bruising	Chest pain	Headaches	Paralysis
Night sweats	Sinus problems	Cold extremities	Dizziness	Memory loss
Fever	Bleeding tendency	Shortness of breath	Tremors	Hearing Loss
Fatigue	Bowel problems	Joint pain	Difficulty walking	Visual change
Weight change	Bladder difficulties	Back pain	Sleeping problems	Numbness/tingling
Other: _____				

Explain: \_\_\_\_\_

### Medications you are taking (include dose, over the counter drugs, and vitamins):

Preferred Pharmacy \_\_\_\_\_ City, State \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

Diseases that run in the family (include deceased family members) \_\_\_\_\_

Do you smoke now? \_\_\_\_\_ Packs per day? \_\_\_\_\_ How long? \_\_\_\_\_ Have you in the past? \_\_\_\_\_  
When did you quit? \_\_\_\_\_ Do you drink alcohol excessively? \_\_\_\_\_ Do you use drugs? \_\_\_\_\_ Have you been  
treated for substance abuse? \_\_\_\_\_

Marital Status \_\_\_\_\_ Number of children \_\_\_\_\_ Do you have a healthcare directive or power of attorney? \_\_\_\_\_

Occupation \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**MIDWEST NEUROSURGERY ASSOCIATES, P.A.**  
**Jonathan D. Chilton, M. D.                      Geoffrey L. Blatt, M. D.**  
**Frank Feigenbaum, M. D.                      William S. Rosenberg, M. D.                      Peter Basta, M. D.**  
**Date \_\_\_\_\_**

**PATIENT INFORMATION**

Name (last)	(first)	(middle)	Social Security #	
Date of Birth	Age	Gender	Marital Status	
Address	City, State Zip		Home Phone	Cell Phone
Employer	Employers Address (city, state, zip)		Work Phone	
E-Mail Address	Spouse/Parent/Significant Other		Contact Phone	
Referring Physician	City, State	Phone	Primary Care Physician	Phone

**EMERGENCY CONTACT**

Name	Relationship to Patient	Contact Phone
Address	City, State, Zip	

**INSURANCE INFORMATION**

Primary Insurance Company	Policyholder/Relationship/Date of Birth	Policy #	Group #/Name
Secondary Insurance Company	Policyholder/Relationship/Date of Birth	Policy #	Group #/Name

DO YOU HAVE REGULAR MEDICARE ? Yes\_\_\_ No\_\_\_    DO YOU HAVE A REPLACEMENT HMO? Yes\_\_\_ No\_\_\_

IS THIS A WORK RELATED INJURY? Yes\_\_\_ No\_\_\_ (If yes, please complete workers compensation form in addition)

IS THIS DUE TO AN AUTO ACIDENT? Yes\_\_\_ No\_\_\_ (If yes, please complete auto information form in addition)

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I authorize payment of medical benefits directly to MIDWEST NEUROSURGERY ASSOCIATES, P.A. I consent to the release of medical information to my insurance company and to my referring physician.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**MEDICARE LIFETIME CERTIFICATE**

I request that payment of authorized Medicare benefits be made on my behalf to MIDWEST NEUROSURGERY ASSOCIATES, P.A. for any services furnished me by these physicians. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature of Beneficiary

\_\_\_\_\_  
Patient Medicare #

\_\_\_\_\_  
Date

**MEDIGAP AUTHORIZATION FORM**

I hereby authorize payment of my Medigap benefits to MIDWEST NEUROSURGERY ASSOCIATES, P.A. for all claims on my behalf. This authorization applies to all services until it is revoked by me or my representative

Beneficiary signature \_\_\_\_\_

Date \_\_\_\_\_

MEDIGAP Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_