Name:
DOB:
Chart:
Age:
Date:

PERSONAL MEDICAL HISTORY (CONFIDENTIAL)

NAME _____
DOB _____ AGE _____ SEX: _____
ADDRESS _____
CITY _____ STATE/ZIP _____
SOCIAL SECURITY # _____
HOME PHONE _____
CELL PHONE _____
WORK PHONE _____
EMAIL _____
MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED
EMPLOYMENT STATUS:
EMPLOYED / RETIRED / UNEMPLOYED / OTHER:
OCCUPATION/EMPLOYER ADDRESS _____

I AM CURRENTLY TAKING AN ANTICOAGULANT:
COUMADIN ASPIRIN PLAVIX OTHER: _____
I HAVE TAKEN STEROIDS/CORTISONE IN THE PAST SIX MONTHS YES / NO

I AM: RIGHT HANDED LEFT HANDED

HEIGHT _____ APPROXIMATE WEIGHT _____

CURRENT MEDICATIONS INCLUDING HERBAL SUPPLEMENTS ALONG WITH DOSE AND FREQUENCY:

ALLERGIC REACTION, INCLUDING RASH OR FAINTING, TO ANY OF THE FOLLOWING DRUGS:

NONE PENICILLIN SULFA ANTIBIOTICS _____
CODEINE DEMEROL MORPHINE ASPIRIN DARVON
DARVOCET VICODIN LORCET PERCODAN / PERCOCET
IODINE OR OTHER XRAY CONTRAST DYES DIURETICS
ANTICONVULSANTS (DILANTIN, PHENOBARBITAL, TEGRETOL, DEPAKOTE)
NONSTEROIDAL ANTI INFLAMMATORY DRUGS LATEX ALLERGY
OTHER DRUG / FOOD ALLERGIES _____

EMERGENCY CONTACT _____
REFERRAL FROM _____
PRIMARY CARE PHYSICIAN _____
SEND MEDICAL REPORT TO ABOVE DR YES / NO

I HAVE SEEN THIS DOCTOR IN THE PAST:
DR. JUSTIN HAYDEL DR. JUSTIN LUNDGREN DR. LUCIEN MIRANNE
DR. EVERETT ROBERT DR. NAJEEB THOMAS DR. RAND VOORHIES
DR. KEVIN MARTINEZ

I AM BEING SEEN TODAY FOR _____

INJURY RELATED TO: MOTOR VEHICLE / JOB
OTHER: _____
DATE OF INJURY _____

I HAVE BEEN TREATED WITH THE FOLLOWING:
PHYSICAL / OCCUPATIONAL THERAPY CHIROPRACTOR
BRACING SPINAL INJECTION OTHER _____

I HAVE BEEN TESTED WITH THE FOLLOWING:
XRAYS CT SCAN MRI MYELOGRAM
EMG / NERVE CONDUCTION STUDY OTHER _____

I HAVE HAD THE PAST MEDICAL ISSUES:
HEART DISEASE HYPERTENSION (HIGH-BP) PNEUMONIA ASTHMA
HAY FEVER TUBERCULOSIS OR POSITIVE SKIN TEST ANEMIA
BLEEDING TENDENCIES HISTORY OF BLOOD TRANSFUSION
CHRONIC LUNG DISEASE SKIN PROBLEMS HIATAL HERNIA
PEPTIC ULCER COLON PROBLEMS KIDNEY PROBLEMS
LIVER DISEASE HEPATITIS / JAUNDICE SLEEP APNEA GOUT
SPINE PROBLEMS / DISC RUPTURE PSYCHIATRIC PROBLEMS
HEAD INJURY / CONCUSSION HIV / AIDS CANCER / TYPE: _____
DIABETES

I HAVE HAD THE PAST SURGICAL PROCEDURES:
NONE GALL BLADDER COLON SURGERY BREAST SURGERY
HEART SURGERY HYSTERECTOMY PROSTATE CARPAL TUNNEL
TONSILS / ADENOIDS C-SECTION APPENDECTOMY KNEE SURGERY
BLOOD VESSEL SURGERY HEMORRHOIDECTOMY HERNIA REPAIR
SPINAL SURGERY _____ OTHER _____

Name:
DOB:
Chart:
Age:
Date:

REVIEW OF CURRENT PROBLEMS OF NEUROLOGICAL SYSTEM:

HEADACHES	LOSS OF HEARING / TINNITUS
MEMORY LOSS	LOSS OF TASTE
CONFUSION	PERSONALITY CHANGES
LOSS OF SMELL	SPEECH PROBLEMS
NIGHT SWEATS	HOARSENESS / VOICE CHANGES
FAINTING / SYNCOPE	WALKING / GAIT DIFFICULTY
VERTIGO / DIZZINESS	SEIZURES / EPILEPSY
RECENT FEVER / CHILLS	VISION CHANGES / HEARING DISORDERS

DO YOU FEEL THAT YOU ARE TENSE OR HIGH STRUNG PERSON? YES / NO

DO YOU FEEL THAT HOME OR WORK IS UNPLEASANT? YES / NO

DO YOU HAVE DIFFICULTY MAKING UP YOUR MIND? YES / NO

DO YOU HAVE PERIODS OF DEPRESSION OR MELANCHOLY? YES / NO

DO YOU HAVE PERSISTANT FEARS? YES / NO
ARE YOU INCLINED TO WORRY EXCESSIVELY? YES / NO
ARE YOU EASILY IRRITATED OR UPSET? YES / NO
ARE YOUR FEELINGS EASILY HURT? YES / NO
ARE EMOTIONAL PROBLEMS IMPORTANT IN YOUR PRESENT ILLNESS? YES / NO

GENERAL REVIEW OF CURRENT PROBLEMS:

RECENT BLEEDING PROBLEMS	CHANGE IN APPETITE
CHRONIC SORE THROAT	WEIGHT LOSS
CHRONIC COUGH / ASTHMA	BLADDER/URINARY SYMPTOMS
SHORTNESS OF BREATH	CHRONIC SKIN PROBLEMS
CHRONIC FATIGUE/TIREDNESS	JOINT PROBLEMS
STOMACH/INTESTINAL PROBLEMS	CHANGE IN BOWEL HABITS
DEPRESSION	HIGH BLOOD PRESSURE / CHEST PAIN / IRREGULAR HEART BEAT
DIABETES	

SOCIAL HISTORY:

DO YOU USE TOBACCO? YES / NO HOW OFTEN _____
DO YOU USE ALCOHOL? YES / NO HOW OFTEN _____

FAMILY HISTORY:

	FATHER	MOTHER	BROTHER	SISTER
HEART DISEASE				
CANCER				
DIABETES				
BLEEDING				
TB				
HYPERTENSION				
STROKE				
SEIZURE/ EPILEPSY				
MIGRAINE				
KIDNEY DISEASE				

FINANCIAL RESPONSIBILITY

1. Unless arrangements have been made in advance, **co-payments, co-insurance, and any outstanding balances are expected at the time of service.**
2. Any check returned from the bank will result in an additional $25 charge that will appear on your account.
3. Patient accounts not paid promptly are subject to third party collections and/or legal procedures.
4. If your insurance carrier has not responded to a claim within 45 days, we reserve the right to formally transfer all associated liability for the claim to you. Failure to promptly resolve this balance may result in third party collection and/or legal procedures to be taken.
5. Your health insurance contract is between you and your insurance company. Any complaints regarding your coverage should be directed to your carrier. If you have obtained health insurance, your insurer may pay some or all of those charges on your behalf, depending upon the coverage purchases. Pre-authorization by your health plan is not necessarily a guarantee of payment. Plans review the claim to determine eligibility and benefits for the services before payment is made.
6. Each health plan establishes its own rules and definitions of what is medically necessary of reimbursement by the plan and what is excluded from coverage. This may not be consistent with your expectations or reimbursement from prior visits and may not have been communicated to us or to you before your services are rendered. Accordingly, your health plan may or may not pay for all services you receive.
7. We will submit a claim on your behalf and advise if your health plan determines some or all of your care or testing is not eligible for coverage. You are financially responsible for charges your health plan determines are not covered.
8. Your insurance company may also determine that your plan requirements were not met or that an approved service provider was not used. You are welcome to receive care or testing but you will be financially responsible if your health plan reduces or denies benefits because the provider you see is not a participating provider.
9. You are responsible for notifying our office of any change in name, address, phone, of insurance information.

(INITIAL) _____ **You are not permitted to audio or video record any portion of your visit to Southern Brain & Spine ("SBS") without the expressed written consent of SBS.**

Please silence all electronics before entering the exam room.

PATIENT/GUARANTOR SIGNATURE _____ **DATE** _____

The above is true and correct to the best of my knowledge and I understand my financial responsibility.

PHYSICIAN SIGNATURE _____ **DATE** _____

I have reviewed the history with the patient.

Name:
DOB:
Chart:
Age:
Date:

Southern
BRAIN & SPINE

RECORD RELEASE AUTHORITY

I, 'FNAME LNAME, hereby authorize Southern Brain & Spine to release such information as necessary and proper for completion of insurance claims, liability or compensation reports on me as deemed fit and proper. I do also authorize communication, either written or verbal, about my medical condition to my referring physician, primary care physician, treating physician(s), attorney, workers compensation carrier and/or their representative (i.e. nurse case managers, utilization review organizations), and/or the party referring me for neurosurgical evaluation.

It is understood that these matters will be treated with tact and discretion as necessary to maintain a professional doctor patient relationship.

I do understand that this release remains in effect until terminated by patient or legal guardian, in writing. A photocopy of this can be considered as valid as an original.

Records to be released to the following:

PCP: _____

Treating Physician(s): _____

_____

Referring Physician: _____

Worker's Comp. Carrier: _____

Attorney: _____

Family Member / Other: _____

X _____ _____

Patient Signature or Legal Representative **Date**

_____

SBS Employee / Witness

Name:
DOB:
Chart:
Age:
Date:

NOTICE FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

PRIVACY NOTICE
Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: Southern Brain & Spine ("Clinic") is permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment and health care operations of Clinic. For treatment purposes, such disclosures may be made to physicians and other health care providers as necessary to effectuate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third party payers for the purpose of obtaining payment for services provided. Clinic may also use personal health information to carry out Clinic day to day operations such as scheduling, quality review and appointment reminders. You agree that Southern Brian & Spine may request and use your prescription drug history from other healthcare providers and third party pharmacy benefit payors for treatment purposes. A list of other examples of disclosures can be obtained from the Privacy Officer upon request.

Required Authorization: Clinic will not disclose any patient's personal health information for any purpose aside from payment, treatment and health care operations, without patient's authorized consent to such disclosure. Upon request for such authorization, patient shall have the right to refuse and/or revoke any disclosure of patient's personal health information.

Privacy Compliance: In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45CFR Parts 160 and 164 (the "Privacy Regulations"), Clinic has adopted privacy policies regarding usage of patient's personal health information. Clinic is committed to compliance with the Privacy Regulations and all other laws and regulations regarding patient's right to privacy.

Additional Information: For additional information regarding Clinic's privacy policy for a copy of this notice, please contact our Privacy Officer. Clinic reserves the right to change this Notice and to make the revised and changed notice effective for medical information that Clinic already has about you, as well as any information Clinic receives in the future. We will post a copy of the current notice in Clinic. The notice will contain the effective date.

The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.

Patient Signature _____ Date _____

Name:
DOB:
Chart:
Age:
Date:

Assignment of Benefits Form

Southern Brain & Spine
3798 Veterans Memorial Blvd Ste 200
Metairie, LA 70002

Date _____

Patient _____

Employer _____

Insurance _____

ID# _____

I hereby instruct and direct _____ Insurance Company to pay my doctor for his professional or medical services rendered, otherwise payable to me, by check, mailed to the above address, **OR**, if my current policy prohibits direct payments to my doctor, I hereby also instruct and direct my insurance company to make out the check to me and mail it to the address above for my doctor.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my care to any insurance company, adjuster, or attorney involved in this case.

I authorize my doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this _____ day of _____, 20 _____.

_____
Signature of Policyholder

_____
Signature of Claimant, if other than Policyholder

Name:
DOB:
Chart:
Age:
Date:

MEDICATIONS LIST FORM

Please list all prescription and over the counter medications, vitamins and natural supplements.			
Medication Name	*Strength*	*Dosage (How you take the meds)*	*Reason you take this drug*

Do you have any drug allergies?
If yes, please list: _____

You MUST provide the below info:

Pharmacy Name	Pharmacy Phone Number

Height:
Weight:

Are you a smoker? Yes / No
If yes, how often & approximate year you started:

PLEASE PROVIDE EMAIL ADDRESS SO THAT WE CAN BETTER ASSIST YOU IN YOUR MEDICAL CARE: