THE INSTITUTE OF BRAIN AND SPINE SURGERY

David F. Morgan, M.D. | N.A. Nabavi, M.D.
Melvin Snyder, M.D. | Mark Sedrak, M.D.

Patient Information

Date:

Please fill out these forms as completely as you can and be sure to sign where indicated.

Patient Name:_____
Home Address:_____
City:_____State:_____Zip Code:_____
Home Telephone: ( ) _____Work Telephone: ( )_____
Gender:_____Male_____Female Marital Status:_____S_____M_____W_____D
Birthdate: Month_____Day_____Year_____Age:_____
Social Security Number:_____Driver's License:_____

Employer:_____Phone Number:_____
Employer Address:_____State:_____Zip Code:_____
Parent or Spouse Name:_____DOB:_____
Home Telephone:_____Work Phone:_____
Emergency Contact:_____Phone:_____

Referring Physician:
_____Address:_____Zip:_____
Telephone #: ( )_____

Insurance Information: Please complete information relative to this office exam.
Is this an automobile accident?_____Is this work related injury?_____

Primary Carrier: Name:_____
Address:_____
Subscriber's Name:_____DOB:_____
SS #:_____Grp.#:_____Policy#:_____

Secondary Carrier: Name:_____
Address:_____
Subscriber's Name:_____DOB:_____
SS #:_____Grp.#:_____Policy#:_____

Worker' Carrier: Name:_____
Address:_____
D/I:_____Claim#:_____
Adjuster's Name:_____Phone#:_____

Attorney: Name:_____Address:_____
Auto Carrier: Name:_____Policy:_____
Address:_____Phone#:_____

I hereby assign to The Institute of Brain and Spine Surgery all benefits provided by my insurance policy for medical and surgical care. I understand that unless I am a member of a prepaid plan with a contract with THE INSTITUTE OF BRAIN AND SPINE SURGERY, INC., or am covered under workers compensation insurance I am responsible to pay for all medical and surgical care and treatment, regardless of whether or not my insurance provides such benefits. Authorization is hereby granted for release of information to my insurance company, to other physicians who may be involved in my medical care and any other persons of legal entities where required by law or good medical practice. A copy of this form has the same authority as the original.

Patient's or Authorized Person's Signature_____Date:_____

The Institute of Brain and Spine Surgery
1360 W. 6th Street, Suite 160W, San Pedro, CA 90732 • (310) 548-5511
21350 Hawthorne Blvd., Suite 176, Torrance, CA 90503 • (310) 540-0965
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General History

Name: Date:

PLEASE ANSWER TO THE BEST OF YOUR ABILITY. USE BACK SIDE, IF NECESSARY.

PAST MEDICAL HISTORY

Otherwise in good health (any serious illness?)	Y N	If not,
Any previous surgery	Y N	If yes
Any previous major fracture	Y N	If yes
Alcohol use: Never, Rarely, Moderately, Ever	N R M E	
Tobacco: Never, Use to, Smoke Now	Y N	_____Packs per day for _____ years
Allergic to any medication	Y N	If yes, Penicillin or other antibiotics Sulfa drugs Iodine Others_____
Currently taking medication	Y N	If yes,

FAMILY MEDICAL HISTORY

Family history not available (adoption, for example)		Y N	If not,
Father: Living and Well, Deceased, Poor Health		Y N	If yes
Mother: Living and Well, Deceased, Poor Health		Y N	If yes
Siblings: _____ Total	_____In poor health due to:_____		_____ Deceased due to:
Children: _____ Total	_____In poor health due to:_____		_____ Deceased due to:
Family history of medical problems? (Please circle)		Y N	Cancer Diabetes Heart trouble High blood pressure
Stroke Convulsions Suicide Mental Illness Bleeding tendency Gout or arthritis Hereditary defects Tuberculosis			

REVIEW OF SYSTEMS

Y N		
	Review of systems essentially unremarkable	
	PLEASE CIRCLE APPROPRIATE SYMPTOMS	
	System	Symptoms
	Head Neck	Headaches Migraines Stiffness
	Eyes Nose Throat	Cataracts Glaucoma Blindness Allergies Sinusitis Impaired hearing Dizziness
	Chest	Asthma Emphysema Difficulty breathing Pneumonia Chronic cough URI(cold) now
	Heart	Heart attack High blood pressure Chest pain Shortness of breath Murmur
	Abdomen	Ulcer Hepatitis Colitis Gallbladder disease Vomiting Bleeding in bowel movements
	Genitourinary	Loss of urine Frequent urination Nighttime urination Blood in urine Kidney trouble
	Skin	Cancer Skin disease Hives or rash Infections Abnormal skin markings
	Tumors	Cancer of any kind (lung, breast, prostate, others) Other tumors
	Neurological	Memory difficulty Seizures Paralysis Speech difficulty Walking difficulty Fainting
	Psychiatric	Psychiatric care Depression
	Hematological	Bleed or bruise easily Slow to heal Anemia Phlebitis Blood disease
	Endocrine	Thyroid disease Hormone therapy

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Name: Date:

MAIN SYMPTOMS

What symptoms do you feel? (pain, weakness, numbness, headache, vision difficulty, etc)

Where do you feel your symptoms? (neck, arm, back, leg, right side, head, etc)

When did you first notice these symptoms?

How did it start (accident, injury, spontaneous, etc)? Describe onset.

At the start, what did you feel first and where? (pain in the left, pain in the right eye, etc)

PREVIOUS PROBLEMS

Have you had similar problems at any time?

If so, when? How did it get better? (surgery, physical therapy, epidural steroids, mediciation, rest, etc)

SINCE ONSET

What treatment have you had? (surgery, physical therapy, epidural steroids, mediciation, rest, etc)

If treated, where and when did you have the treatments?

Have you had remissions/relapses (better/worse) and when?

Which doctors have you seen for this problem?

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Name: Date:

PRESENT COURSE

Are your symptoms better, worse, same since they started?

Are they aggravated by sitting, standing, walking, or any other activities? If so, how far can you walk and how long can you stand?

Are you having difficulty with balance, coordination, speech, vision?

Are you having changes in your sleep or weight patterns?

Are you working now? If you stopped, when and why? If you restarted, when?

What medications are you taking for this problem?

What tests have you had? (MRI, CAT scan, EMG, etc)

OTHER

What else would you like me to know about your problem?

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THE INSTITUTE OF BRAIN AND SPINE SURGERY NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access that information. Please review it carefully.

At The Institute of Brain and Spine Surgery we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, your file may be reviewed by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

As we will need to contact you from time to time, we will whatever address or telephone number you prefer. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers your phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for them.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. You may file a complaint with the Department of Health and Human Services, 200 Independence Ave, S.W., Rm 509 F, Washington DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for assistance regarding your health information, please contact our Privacy Officer, Daisy Pakingan, (562-432-8780). (Wed-Fri.)

This notice goes into effect as of April 14, 2003.

ACKNOWLEDGMENT

I have received a copy of The Institute of Brain and Spine Surgery Notice of Privacy Practices.

Date_____

Signed_____Print Name_____

If signing as a parent or guardian, please note the name of the patient,_____

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