THE GEORGIA NEUROSURGICAL INSTITUTE, 840 PINE STREET, SUITE 880 MACON, GA 31201 (478-743-7092)

How did you hear about our practice? □ Doctor Referred □GNI Web Site □Billboard

□Print □Online □ Patient: ____

Today's Date ______/_______/_______

Pharmacy Name, Address and Phone Number

____

____

Patient Last Name First Middle			Marital Status: □ Single □Married □ Divorced □Separated □ Widowed
Race: □Black/African American □ Hispanic □ White □Asian □ Other			E- Mail Address:
Mailing Address	Social Security Number		Birth Date / / Age Sex □ M □ F
City State Zip	Primary Phone ( )		Cell Phone ( )
Emergency Contact	Phone ( ) Cell ( )		Relationship to Patient
Patient's Employer:		Occupation:	
Referring Physician		Primary Care Physician	

INSURANCE INFORMATION

Primary Insurance	Policy Number	Group Number
Subscriber's Name	Subscriber's Social Security Number	Birth Date / /
Patient's Relationship to Subscriber	□ Self □ Spouse □ Child	□ Other
Secondary Insurance	Policy Number	Group Number
Subscriber's Name	Subscribers Social Security Number	Birth Date / /
Patient's Relationship to Subscriber	□ Self □ Spouse □ Child	□ Other

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone ( ) -

Is this a Worker's Compensation Claim? □ Yes □ No
DOI:________________________________ Claim #:___________________________________

Adjuster's Name: ________________________________ Adjuster's Phone Number:_______________________

Is the injury related to an auto accident? □ Yes □ No

Date of Accident: __________________ Adjuster's Name: _____________________________________

Name of Auto Ins: ______________________________ Claim #: _________________________________

Do You have an attorney? □ Yes □ No Name and Phone # of Attorney _________________________________

Medications	Dosage	Frequency (How Often)	Prescribing Physician

CHIEF COMPLAINT

Onset of Pain: ______/_______/_______

Explain, in your own words, your problem today: ____
____

Did you have to go to the emergency room? □ Yes □ No

If yes, please list name of Emergency Room and give date treated:

____

____

PAST MEDICATIONS USED TO TREAT MY BACK/LEG/NECK/HEAD SYMPTOMS

	Did It Help?			
□ Aspirin	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Pain Tylenol	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Motrin / Ibuprofen / Advil	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Darvon / Darvocet	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Vicodin / Hydrocodone	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Mobic / Celebrex	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Percocet / Oxycodone	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Valium	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Muscle Relaxants	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Lyrica / Neurontin	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Antidepressants	□ Yes	□ No	Begin Date: ___________	End Date: ___________
□ Other ____			Begin Date: ___________	End Date: ___________

ALLERGIES

Are you allergic to latex? □ Yes □No

Are you allergic to shellfish? □ Yes □No What type of Shellfish? ____

Are you allergic to any type of tape? □ Yes □ No List: ____

Are you allergic to any medications? □ Yes □ No List: ____

Are you allergic to any foods? □ Yes □ No List: ____

Other Allergies: ____

HOSPITALIZATIONS OR ANY TYPE OF SURGERY

Please list ALL surgeries Date of surgery Complications

____

____

____

____

□ I have never had surgery

PREVIOUS TREATMENTS

Please include when and where any of the following treatments were performed (only on body part you're being treated for today). IN THE PAST 6 MONTHS

Epidural Steroid Injections: □ Yes □ No Begin Date:__________________ End Date:____________________
Where:____

Physical Therapy for 6 to 8 weeks: □ Yes □ No Begin Date:_________________ End Date:____________________
Where:____

Home Exercises for 6 to 8 weeks: □ Yes □ No Begin Date:_________________ End Date:____________________

TENS Unit/ Massage Therapy: □ Yes □ No Begin Date:_________________ End Date:____________________

Other: ____

PLEASE LIST PHYSICIANS THAT HAVE TREATED YOU IN THE PAST

Neurosurgeon:	
Orthopedic Surgeon:	
Neurologist:	
Last Physical Exam:	
Physiatrist:	
Psychiatrist:	**Suicide Attempt □ Yes □ No**
Chiropractor:	
Rheumatologist:	
Pain Clinic:	
Other:	

FAMILY HISTORY

	HIGH BLOOD PRESSURE	DIABETES	CANCER	HEART DISEASE	BLEEDING DISORDER	LUNG DISORDER
FATHER						
MOTHER						
BROTHER(S)						
SISTER(S)						
CHILDREN						

SOCIAL HISTORY

Highest level of Education: ____

Smoking History: □ Never □ Quit □ I currently smoke ____ packs each day □ Cigars □Chewing Tobacco

Alcohol Use: □ Never □ Occasionally □ Daily □ Former Drinker

With which hand do you write? □ Left □ Right Weight ______________ Height __________________

PLEASE INCLUDE WHEN, WHERE AND DATE THE TEST WAS PERFORMED

(On body part you are being treated for today)

X-Ray/ CT: ____

MRI: ____

Myelogram/Dsicogram:____

Bone Scan: ____

Electrical Nerve Testing (EMG): ____

Nerve Root or Facet Injection: ____

Please Check if You Have Ever Been Diagnosed or Treated for Any of the Following:

If female, are you pregnant □ Yes □ No

- □ Anemia (Low Blood Count)
- □ Bleeding Ulcers / Bleeding Disorder
- □ Deep Vein Thrombosis/ Blood Clots
- □ Varicose Veins
- □ Hip Pain
- □ Neck, Back Pain (please circle)
- □ Extremity Pain Right Left Both
- □ Arthritis / Gout
- □ Foot / Toe Pain Right Left Both
- □ Difficulty Walking

- □ Headaches
- □ Seizures
- □ Syncope / Passing Out / Dizziness
- □ Epilepsy
- □ Hearing Loss
- □ Difficulty Swallowing / Speaking
- □ Tremors
- □ Bipolar Disorder
- □ Heat or Cold Intolerance

CARDIO

- □Heart Attack/MI Year____________
- □A-FIB (Atrial Fibrillation)
- □Heart Cath Year______ Stents_________
- □Pacemaker Year_________
- □Irregular Heartbeat
- □Congestive Heart Failure
- □Heart Murmur
- □Mitral Valve Prolapse
- □High Blood Pressure
- □High Cholesterol
- □Stroke / TIA / CVA
- □ Blood Thinners

GI / UROLOGY

- □ Diverticulosis / Diverticulitis
- □ Crohn's Disease
- □ Ulcerative Colitis
- □ Renal Failure
- □ Kidney Stones
- □ Prostate Trouble
- □ Swelling (Edema) Location _______________
- □ Urinary Tract Infection
- □ Sexual Malfunction
- □ Acid Reflux/GERD

PULMONARY

- □COPD
- □History of Pulmonary Embolism
- □ Pneumonia
- □Emphysema
- □ Use CPAP Machine
- □Asthma
- □Obstructive Sleep Apnea
- □On Oxygen? __________ □ 24 hours or □ Bedtime Only

DO YOU HAVE

- □ HIV / AIDS/ Venereal Disease
- □ Hepatitis A B C D
- □ Tuberculosis / Positive Skin test Date: __________
- □ Lupus
- □ Fibromyalgia
- □ Chemical Dependency
- □ Liver Disease
- □ Graves Disease

THYROID

- □Hyper
- □Hypo
- □ Endocrine Disorder
- □Goiter

Diabetes: □ Type 1 □ Type 2
How Long? _______________
Is it under control? □Yes □No

CANCER: Location: __________________
Diagnosed Date: ____________

Chemo? □Yes □No How many treatments? _________
Radiation? □Yes □No How many treatments? _________

Please check box for positive symptoms and describe or add others, if needed.

Constitutional:
- ☐ fever
- ☐ weight gain
- ☐ weight loss
- ☐ loss of appetite

Skin:
- ☐ lesions
- ☐ Rashes

Eyes:
- ☐ double vision
- ☐ blurring
- ☐ difficulty seeing

ENT:
- ☐ deafness
- ☐ hoarseness
- ☐ vertigo

Cardiovascular:
- ☐ palpitations
- ☐ irregular/rapid heartbeat
- ☐ chest pain

Respiratory:
- ☐ wheezing
- ☐ shortness of breath
- ☐ chronic cough

Digestive:
- ☐ abdominal pain
- ☐ constipation
- ☐ diarrhea
- ☐ bowel incontinence

Urinary:
- ☐ pain with urination
- ☐ hesitancy
- ☐ urinary incontinence

Psychiatric:
- ☐ anxiety
- ☐ sleep disturbances
- ☐ depression

Musculoskeletal:
- ☐ stiffness
- ☐ joint pain/deformity
- ☐ spine pain
- ☐ muscle wasting
- ☐ weakness
- ☐ pain radiating to arms/legs

Neurological:
- ☐ loss of balance/coordination
- ☐ paralysis
- ☐ numbness
- ☐ loss of sensation in arms/legs
- ☐ tingling
- ☐ loss of memory
- ☐ facial pain

Other Current Symptoms:

____

____

____

____

THE GEORGIA NEUROSURGICAL INSTITUTE
840 PINE STREET, SUITE 880, MACON, GA 31201 (478-743-7092)

1. **I understand I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).**

2. **I authorize my insurance carrier to release information regarding my coverage to Georgia Neurosurgical Institute, PC. I also authorize previous physicians to furnish Georgia Neurosurgical Institute, PC copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed, including for the purpose of initiating claim denial(s)/ reconsideration on my behalf. I also agree to a review of my records for purpose of the internal audits, research and quality assurance reviews within Georgia Neurosurgical Institute, PC.**

3. **My right to payment for pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Georgia Neurosurgical Institute, PC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plan. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, <u>or if payments are made directly to me or my representative, I will endorse such payment to Georgia Neurosurgical Institute, PC.</u>**

4. **I understand that my patient information arising out of my medical treatment by my physician practice (without identifying me or any other patient by my name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) governmental bodies (such as the FDA and HCFA); (c) representatives and agents of my health benefit plan; (d) persons conducting quality or peer review or patient satisfaction surveys; (e) other clinical and non-clinical parties that have a contractual relationship with Georgia Neurosurgical Institute, PC.**

5. **<u>PERSONAL VALUABLES:</u> I acknowledge that Georgia Neurosurgical Institute, PC shall not be liable for the loss or damages to any personal property.**

6. **<u>CONSENT FOR PHOTOGRAPH:</u> I, the undersigned, give Georgia Neurosurgical Institute, PC, its physicians and staff, permission to make photographs of me for placement into my clinical record.**

7. **By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s).**

THIS AGREEMENT/ CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

____ ____________________

Patient Signature **Date**

____ ____________________

Responsible Party Signature **Relationship to Patient** **Date**

GEORGIA NEUROSURGICAL Institute GNI

BRAIN & SPINE SPECIALISTS

I hereby agree to let individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Georgia Neurosurgical Institute physicians and staff to disclose my personal medical information to the following individuals (family members, friends, spouse, attorney, etc.):

Name:	Relationship to patient	Phone ( )
Name:	Relationship to patient	Phone ( )
Name:	Relationship to patient	Phone ( )
Name:	Relationship to patient	Phone ( )

Condition for Disclosure (Check the Item(s) that apply):

___ The practice may disclose my personal health information to the individual(s) above only in my presence.

___ The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile, email, or regular mail.

___ Other conditions of disclosure: (Please specify)

___

I understand that this consent may be revoked by me at any time by written notice to the practice.

Signature ___ ***Date:***___