DALLAS
BRAIN, SPINE &
SKULL BASE SURGERY

HEALTH HISTORY QUESTIONNAIRE

Name (First Last):		Today's Date:
DOB:	☐ Male ☐ Female	Height: Weight:
Children? ☐ Yes ☐ No If yes, how many? _____		
When was your last flu vaccine? _____	When was your last pneumonia vaccine? _____	
Occupation: ☐ Retired ☐ Disabled ☐ Working Current occupation _____		
Reason for today's visit:		

PERSONAL HEALTH HISTORY

Chronic Health History: (Diabetes, Hypertension, etc…) Circle all that apply

Cancer ☐ Type:_____	Diabetes ☐ Type:_____	Psychiatric (ex: depression) ☐ Type:_____
High Cholesterol ☐	History of Stroke ☐	Heart Disease / Heart Murmur ☐
High Blood Pressure ☐	Pacemaker ☐	Heart Attack ☐
Defibrillator ☐	Migraines / Headaches ☐	Acid Reflux / GERD ☐
Sleep Apnea / Insomnia ☐	Thyroid ☐	COPD ☐
Kidney Disease ☐	Prostate Disease ☐	Osteoarthritis/ Rheumatoid Arthritis ☐
Bleeding Disorder ☐	Easy Bleeding ☐	Seizures ☐
OTHER:_____ ☐		

Past Surgical History:

Year	Reason (example: appendectomy)	Location (example: Medical City)

Other Hospitalizations:

Year	Reason	Location

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Patient Name: DOB:

HEALTH HABITS

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many glasses a week?_____What type of alcohol?_____

_____

Tobacco

Do you use tobacco? ☐ Yes ☐ No ☐ Never, quit / year _____

If yes, check all that apply: ☐ Cigarettes / # a day_____ ☐ Chew /_____times a day

☐ Pipe /___times a day ☐ Cigars / # a day _____

Do you use illicit drugs? ☐ Yes ☐ No but I used to DETAILS: _____.

☐ Never

PLEASE CIRCLE ALL THAT APPLY TO YOUR HEALTH CARE **CURRENTLY**

CONSTITUTIONAL

Weight Gain ☐
Weight Loss ☐
Night Sweats ☐
Chills/Fever ☐

CARDIO AND VASCULAR

Rheumatic Fever ☐
Syncope/Fainting ☐
Swelling in feet ☐
Chest Pain or
Angina Palpitations ☐
Atrial Fibrillation ☐

NEUROLOGICAL

Numbness ☐
Weakness ☐
Memory Loss ☐
Balance problems ☐
Blackouts ☐
Inability to concentrate ☐

MUSCULOSKELETAL

Leg / Arm Pain ☐
Leg / Arm ☐
Weakness
Back/Neck Pain ☐

RESPIRATORY

Shortness of Breath ☐
Asthma / Wheezing ☐
Snoring ☐
Trouble breathing at night ☐
Coughing up blood ☐
TB /Tuberculosis ☐
Pneumonia ☐

EYES

Double Vision ☐
Visual Loss or Changes ☐

EAR, NOSE, THROAT AND MOUTH

Hearing Loss ☐
Noise / Ringing in
Ears Drainage from ☐
Ears Nasal ☐
Congestion Nasal ☐
Drainage Inability to ☐
Smell ☐
Sore Throat ☐
Trouble
Swallowing ☐
Hoarseness ☐
Vertigo / Dizziness ☐

ALLERGIC / IMMUNOLOGIC

Sneezing ☐
Itching
Eyes Itchy ☐
Throat Skin ☐
Rash ☐

HIV ☐

GASTROINTESTINAL

Abdominal Pain ☐
Blood in Stool ☐
Black Tarry
Stool ☐
Bowel Incontinence ☐
Hepatitis ☐
Jaundice ☐
Liver
Trouble ☐
Ulcer ☐
Nausea / Vomiting ☐

GENITOURINARY

Urinary Incontinence ☐
Bladder Trouble ☐
Blood in Urine ☐
Sexual Dysfunction ☐

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PERSONAL SAFETY

Do you live alone? ☐ Yes ☐ No
Do you use a cane? ☐ Yes ☐ No
Do you have frequent falls? ☐ Yes ☐ No
Do you use a wheelchair? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

	Age	Health Problems	Age at Death		Age	Health Problems	Age at Death
Father				Paternal Grandfather			
Mother				Paternal Grandmother			
Sibling(s)				Maternal Grandfather			
Children				Maternal Grandmother			

ALLERGIES

Have you ever had a problem / reaction with anesthesia? ☐ Yes ☐ No
If yes, please explain:

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list allergy and reaction below

Allergy/Medication	Reaction

Patient Name: _____ DOB: _____
Today's Date: _____

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Patient Name: _____ DOB: _____

Enter your medications below (include over the counter medications, vitamins, supplements, and Aspirin) or attach your medication list.

Pharmacy Name & Location _____ Phone # _____

MEDICATIONS			
Name	Dose / Strength	Frequency	Prescribing Physician
Example: Metoprolol	*40 mg*	*2 tabs in a.m. & 1 tab in p.m.*	*Dr. Jon Smith (Internal Medicine Doctor)*

☐ Not currently taking any medications (check here)

To the best of my knowledge, all the information provided regarding my health, is complete and correct. I understand that it is my responsibility to inform Dallas Brain, Spine & Skull Base Surgery if I have any changes in my health, or health information.

_____ _____

Signature of Patient Date

DALLAS
BRAIN, SPINE &
SKULL BASE SURGERY

Patient Name:_____ DOB: _____

Referring Physician: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

Primary Care Physician: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

Additional Physician: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

HOW DID YOU LEARN ABOUT US?

(Circle all that apply)

- ☐ Referring Provider
- ☐ Family/Friends
- ☐ Search Engine
- ☐ Physician Directory
- ☐ Website
- ☐ Blog
- ☐ Facebook
- ☐ Twitter
- ☐ HealthGrades.com
- ☐ Vitals.com
- ☐ Yelp.com
- ☐ Google Places Page
- ☐ D Magazine
- ☐ Other

DALLAS BRAIN, SPINE & SKULL BASE SURGERY

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Name (if different from above): _____Patient Social SecurityNumber_____

Address: _____City, State, Zip:_____

Home Phone Number (landline):_____ Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer
☐ Choose not to disclose ☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Chose not to disclose
☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French
☐ Indian: Hindi, Tamil, Gujarati etc ☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole
☐ Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐
Portuguese ☐ Cambodian ☐ Other not listed_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)_____(First)_____(MI) _____

Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_____Phone number: _____

Address:_____City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_____ ☐ Guardian

Address_____City, State:_____ZIP: _____

Home phone:_____Work phone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

DALLAS
BRAIN, SPINE &
SKULL BASE SURGERY

Patient Name: _____ **Date of Birth:** _____

Patient Consent for Financial Communications

Financial Agreement:

- I acknowledge, that as a courtesy, Dallas Brain, Spine, and Skull Base Surgery may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection: I acknowledge Dallas Brain, Spine, and Skull Base Surgery may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits: I hereby assign to any insurance or other third-party benefits available for health care services provided to me. I understand Dallas Brain, Spine, and Skull Base Surgery > has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Dallas Brain, Spine, and Skull Base Surgery, I agree to forward all health insurance or third- party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit: I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Dallas Brain, Spine, and Skull Base Surgery by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications: I agree that, in order for Dallas Brain, Spine, and Skull Base Surgery, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Dallas Brain, Spine, and Skull Base Surgery or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Dallas Brain, Spine, and Skull Base Surgery or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:_____**Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

☐Spouse
☐Parent
☐Legal Guardian
☐Guarantor
☐Healthcare Power of Attorney
☐Other (please specify) _____

DALLAS
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SKULL BASE SURGERY

Patient Responsibility Agreement for Prescriptions Written for Pain Management

Pain medications including controlled substances prescribed for pain management require you, the patient, to agree to the following:

1. Lost, misplaced, or stolen medications will not be replaced.
2. Refill requests require 72 business hours' notice and must be faxed by your pharmacist. Prescriptions for controlled substances *have to be picked up at our office*.
3. Pain medications will not be refilled after hours or on weekends/holidays. Refills must be requested during normal business hours.
4. You must inform us if you are being prescribed pain medications prescribed by another physician. We are unable to fill pain medications if you are under a pain management physician's contract.
5. Use pain medications as directed and follow the directions regarding activity limitations and cautions, such as driving, in the interest of safety.
6. No illegal drug use.
7. Violation of any of the conditions stated above may lead to your termination as a patient.
8. Pain medication will not be prescribed long term and you may be referred to a pain management specialist.
9. I authorize Dallas Brain, Spine & Skull Base Surgery to share this agreement with my pharmacy or other physicians as necessary in my treatment with controlled substances.

I have read the above agreement and understand the possible consequence that violating this agreement is subject to termination as a patient.

_____ _____

Patient Signature Date

_____

Printed name of patient

DALLAS
BRAIN, SPINE &
SKULL BASE SURGERY

Financial and Office Policies

By executing this agreement, you are agreeing to pay for all services received

Surgery Changes: We kindly request that in the event you must cancel or reschedule your surgery you give us 72 business hours' notice. If adequate notice is not given for cancellation or rescheduling your surgery you will be responsible for a $150 service fee.

FMLA, Short Term Disability, Leave of absence paperwork: All leave related documents to be filled out by our office is free for the patient the first time only. All subsequent documents requiring revisions or for family members leave of absence will incur a $25 service fee.

Insurance: We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company who makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. Our verification staff is dedicated to ensuring your visit is covered by your insurance or advising you otherwise prior to your appointment. In some instances, we might not be able to obtain this information. It is always a good idea for you to check with your insurance carrier to verify your specific benefits so there are no unexpected financial surprises at the time of your visit. Payment for services is ultimately your responsibility.

Self-pay Patients: All self-pay patients are required to pay at the time the services are rendered. We offer a self-pay discount if the balance is paid in full at the time of service.

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Past Due Account: Your account becomes past due 30 days following the receipt of your first statement. We will take necessary steps to collect this debt. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Waiver of Confidentiality: Please understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact you received treatment at our office may become a matter of public record.

Appointments: It is our goal to provide services to you in the most comfortable and timely manner as possible. In order to achieve this we must require you to be on time for your appointments. *If you are more than 5 minutes late for your appointment, we unfortunately will have to reschedule your appointment.* If you are bringing imaging please arrive early to allow us time to upload you images. If you must cancel an appointment, we ask you give us 24 hours' notice whenever possible. In order to ensure accurate records and true identity of all patients you will need to present your Driver's License or Identification Card, Insurance Card at the time of your appointment.

I have read this document and understand the policies and my responsibilities.

Patient's Name (Print) _____

Signature: _____ Date: _____

Guarantor's Name (Print) (Minor patient's only): _____

Signature: _____ Date: _____