Patient Registration Form

Primary Care Physician: _____ Phone No. _____ Today's Date: _____

PATIENT INFORMATION **(Please Print)**

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Jr. ❑ Sr. ❑ Other_____

Patient's Name (Last) _____ (First)_____ (Middle)_____

Also Known As Name (Last) _____ (First) _____

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Other

Social Security Number _____-_____-_____ ❑ Female ❑ Male Date of Birth_____/_____/_____

E-Mail Address _____ ❑ Check here if you do not wish to receive routine mailings and surveys

Phone Numbers Home _____ ❑ Day ❑ Evening Work_____ ❑ Day ❑ Evening

Cellular _____ Pager _____

Address _____

City, State, ZIP (+4) _____

Employment Status ❑ Employed Full-Time ❑ Employed Part-Time ❑ Student Full-Time ❑ Student Part-Time ❑ Retired ❑ Self-Employed ❑ Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Patient Relationship to Emergency Contact _____

Emergency Contact Phone Number _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____-_____-_____ ❑ Female ❑ Male Date of Birth_____/_____/_____

E-Mail Address _____

Phone Numbers Home _____ ❑ Day ❑ Evening Work_____ ❑ Day ❑ Evening

Address _____

City, State, ZIP (+4) _____

Employment Status ❑ Employed Full-Time ❑ Employed Part-Time ❑ Student Full-Time ❑ Student Part-Time ❑ Retired ❑ Self-Employed ❑ Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Social Security Number _____-_____-_____ ❑ Female ❑ Male Insured Date of Birth_____/_____/_____

E-Mail Address _____

Insurance Company _____ (_____) _____

Subscriber ID (Policy Number) _____ Group ID_____ Copay Amount_____

Effective Date _____ Termination Date _____

Insurance Company Address _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Social Security Number _____-_____-_____ ❑ Female ❑ Male Date of Birth_____/_____/_____

E-Mail Address _____

Insurance Company _____ (_____) _____

Subscriber ID (Policy Number) _____ Group ID_____ Copay Amount_____

Effective Date _____ Termination Date _____

Insured Date of Birth_____/_____/_____ Insurance Company Address_____

I agree that the information on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

(PLEASE TURN OVER)

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for your copay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. I _____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____

Signature Date

I authorized this facility to release information to (Please check all that apply):

- ❑ Spouse: List complete name of spouse _____
- ❑ Children: List complete names of children & phone numbers _____
- ❑ Others: List complete name & phone number of person designated _____
- ❑ No One

_____ _____

Signature Date

Medicare Patients

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished me by the provider. I authorize any holder of medical information about me; to release Medigap Insurer_____any information needed to determine those benefits payable for related services.

_____ _____

Signature Date

MEDICARE LIFETIME AUTHORIZATION

HIC#_____

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

Signed: _____Date: _____

Print Name: _____Title or Relationship: _____

Witnessed by: _____Address: _____

If signed by other than beneficiary, state reason the patient was unable to sign:_____

NEUROSURGERY PATIENT HISTORY

Today's Date___/___/___ **Name** _____ **Date of Birth**___/___/___

Primary Physician: _____ **Doctor's phone#** _____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe problem in detail)

_____

_____

_____

History of Present Illness

Please answer the following questions

Location of the problem?
Head Neck Back Legs
Arms/shoulders
Other _____
_____
_____

On a scale of 1 - 10 with 10 being the most severe, circle the number that best describes the severity of your problem
1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other _____

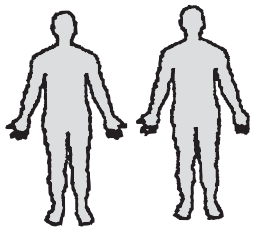
Do you think the problem is related to an accident, injury, or other cause?
YES NO If yes, please explain _____
_____

Does anything help or make the problem worse? ("H" for helps or "W" for worse, leave blank if no effect)
Moving around_____ Standing_____ Bending_____
Sneeze/cough_____ Sitting_____ Walking_____
Lying Down_____ Medications_____
Other _____

Does the problem interfere with your normal functions? Yes No If yes, explain

Indicate location of pain or numbness on the diagram.

Front Back



"X" for pain areas
"O" for numb areas

Have you had treatment for your problem?
Yes No If Yes, please indicate treatment:
physical therapy chiropractic
surgery injections medications_____
Other_____

How long does the problem last?
5 minutes hours always present
Other_____

Is anything else occurring at the same time?
Yes No If yes, please explain
Numbness?
Pins and needles sensation?
Weakness?
Other_____

Is the problem consistant or variable?
Dull then sharp Aching Always there
Shooting or stabbing Other

Physician use only (Notes)

HISTORY-PAST MEDICAL, SOCIAL, FAMILY

List medications you are currently taking_____
Medicine / dosage_____
_____
_____
_____
_____
_____

Do you have any allergies to medicines?
Yes No If yes, please list medicine and your reaction (rash, stomach upset, breathing problems, etc.)
_____
_____
_____

Medical illnesses/problems (examples: diabetes, high blood pressure, heart disease, cancer, depression, etc.)
_____
_____

List previous operations:_____
_____
_____

Family History: (circle as appropriate, list others)
heart disease stroke aneurysm
cancer bleeding problems tuberculosis
major complication from anesthesia
Other _____

Marital status:_____ # of children_____

What is your occupation? _____

Habits:
Do you smoke? Yes No
If yes, how much? _____

Do you drink alcohol? Yes No
If yes, how much? _____

Do you use herbal medicines? Yes No
If yes, please list: _____
_____

Review of Systems

Do you now or have you had problems related to the following systems? Circle Yes or No.
Please explain Yes answers in margin

Constitutional Symptoms
Fever Y N
Weight loss Y N
Headache Y N
Other _____

Eyes
Blurred vision Y N
Double vision Y N
Pain Y N
Other _____

Allergic/Immunologic
Hay fever Y N
Asthma Y N
Other _____

Neurologic
Tremors Y N
Seizure Y N
Numbness Y N
Other _____

Endocrine
Severe thirst Y N
Too hot/cold Y N
Sluggish Y N
Other _____

Gastrointestinal
Nausea Y N
Vomiting Y N
Loss of Bowel Control Y N
Ulcers/Bleeding Y N
Other _____

Cardiovascular
Chest pain Y N
High BP Y N
Other _____

Integumentary
Skin rash Y N
Persistent itch Y N
Boils Y N
Other _____

Musculoskeletal
Joint pain Y N
Broken Bones Y N
Arthritis Y N
Weakness Y N
Other _____

Ear/Nose/Throat/Mouth
Sore Throat Y N
Sinus Problems Y N
Ringing in Ears Y N
Other _____

Genitourinary
Kidney Problems Y N
Painful Urination Y N
Loss of Bladder Control Y N
Other _____

Psychologic
Are you Depressed Y N
Are you Anxious Y N
Considered Suicide Y N
Other _____

Respiratory
Wheezing Y N
Frequent Cough Y N
Emphysema Y N
Shortness of Breath Y N
Other _____

Hematologic/Lymphatic
Swollen Glands Y N
Blood Clotting Trouble Y N
Easy Bruising/Bleeding Y N
Other _____

Physician Use Only:

Physician_____
Date_____/_____/_____

Neuroscience Associates of Kansas City, LLC
Robert M. Beatty, M.D. F.A.C.S.

Patient Name _____

Date of Birth _____

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you.

_____ 1. **Patient With Insurance including Medicare**
You are responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front-desk staff to make other arrangements. A fee of $30.00 will be charged for any returned checks.

_____ 2. **Worker's Compensation Patient**
As a Worker's Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for balance.

_____ 3. **Personal Injury (Accident)**
If you are a personal-injury patient, our office will bill the insurance companies. The charges for the services rendered will be your responsibility. This amount must be paid prior to each visit. If an attorney is involved and asks you not to submit insurance claims, a doctors lien must be signed by you and your attorney.

_____ 1. **Minor Patients**
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

_____ 2. **Missed Appointments**
In order to provide the best possible service and availability to all our patients, it is our policy to charge our office visit fee for any appointments not canceled at least one day prior. Please call us as early as possible if you know you will need to reschedule your appointment.

ASSIGNMENT

_____ I request that payment of authorized Medicare benefits be made either to me or on my behalf to Neurosurgery of Kansas City for service furnished me by that provider. Medicare Number_____

_____ The signature below authorizes payment of mandated Medigap benefits to Neurosurgery of Kansas City.
Medigap_____Policy Number_____Group Number_____

_____ I assign the benefits from my insurance carrier(s) to this clinic for the medical/surgical benefits I am entitled to.

RELEASE OF INFORMATION

_____ I authorize Neurosurgery of Kansas City to release to my insurance carrier(s) and/or CMS (formerly HCFA) and its agents and/or my Medigap insurer any information needed to determine benefits or benefits payable for related services.

I have read and understand the Financial Policy, Assignment, and Release of Information paragraphs stated above that apply to me and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

X _____

Patient or responsible party signature Date

_____

Person signing on behalf of patient (print name) Reason patient can't sign

_____

Relationship to Patient Address Phone
