NEUROLOGICAL SURGERY
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William B. Lujan, M.D.
David R. Siegel, M.D.

NURSE PRACTITIONERS
Amy Alberts AGACNP-BC
Eddie Gilliam, PhD, CFNP

Welcome to Western Neuro

Your appointment is with:

on ____ at ____________________am/pm

Please bring the following for your appointment:

1. The enclosed registration packet COMPLETELY filled out, signed and dated. Please bring the completed packet to your appointment. It is not necessary for you to mail the forms.
2. Your insurance card(s)
3. Your driver's license or other photo identification
4. Payment – your co-payment or patient responsibility amount is required to be paid at the time of your appointment

PLEASE NOTE: YOUR APPOINTMENT WILL BE RESCHEDULED IF YOU ARRIVE MORE THAN 10 MINS LATE AND/ OR WITHOUT YOUR COMPLETED REGISTRATION FORMS.

If you are unable to make your appointment, please call 520-881-8400 to notify our office 24-48 hours in advance.

**** MAIN LOCATION****

6567 E. Carondelet Dr., Suite 305

St. Joseph's Hospital Campus

Phone: (520) 881-8400

Revised March 2018

WESTERN NEURO
Medical History Form - NEUROSURGERY
General Information

Name:______________________________________ DOB ________________ AGE ______ Male/Female Height __________ Weight _________
Email: ____

Name of Family Doctor (Primary Care Physician)____

Who referred you to Western Neurosurgery, Ltd.?____

Medical Information

Why are you here to see the doctor?____

When and how did the problem begin?____

____

What is your major symptom?____

What other doctors have you seen for this problem?____

Have you received any of the following tests or treatments for this problem? Please give dates and locations:

Hospital emergency room or urgent care center ____

X-rays____

CT Scans ____

MRI Scans ____

EMG/NCV ____

Blood tests____

Physical Therapy____

Pain specialist injections____

Chiropractic care____

Other____

Are you able to do everything you did before the problem began? Please explain “No” answers.

Work	Yes No	______________________________
Drive	Yes No	______________________________
Housework	Yes No	______________________________
Yard work	Yes No	______________________________
Sports	Yes No	______________________________
Hobbies	Yes No	______________________________
Second Job	Yes No	______________________________
Sex	Yes No	______________________________

Have your symptoms changed since the problem began? Better/Worse/Unchanged

Is a legal or industrial case pending regarding this problem? Yes_________ No_________

Patient's Name ______________________________________ Today's date______________________________

Pain Scale:

Mark below on the scale from 0 to 10 your level of pain or discomfort.

None Unbearable

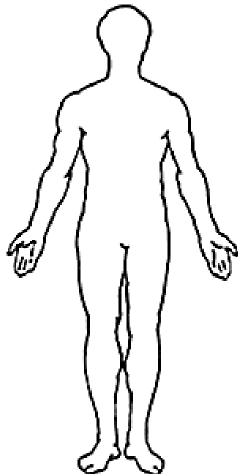
____

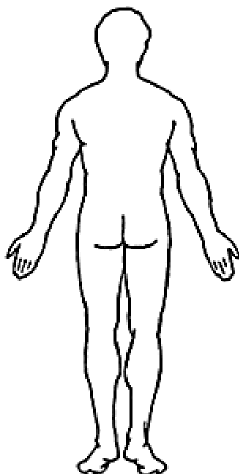
-0- -10-

Pain Drawing:

On the drawing below, please mark the areas on your body where you feel the described sensations. Use the appropriate symbols to represent each sensation. Include all affected areas of your body.

Front Back





Right Left Left Right

Symbols:

////////////	sharp or stabbing pain
= = = =	burning pain
#####	constant ache
xxxxxx	numbness or tingling
00000	increased sensitivity

HEALTH & SYMPTOM REVIEW (REVIEW OF SYSTEMS) Please circle any current symptoms or health problems. Some symptoms may not seem pertinent to your visit but are important for us to know:

- Fever – Chills – Fatigue – Malaise – Appetite Loss – Night Sweats – Weight Gain – Weight Loss
- Blurry Vision – Double Vision – Glasses – Contact Lenses – Change in Vision – Loss of Vision – Eye Pain
- Decreased Hearing – Difficulty Swallowing – Ear Pain – Jaw Pain – Sinus Pain – Taste Disturbance – Ringing in Ears – Vertigo – Hearing Aid(s)
- Shortness of Breath – Cough – Wheezing – Sleep Apnea (CPAP / BiPAP) - Excessive Snoring
- Chest Pain – Palpitations – Irregular Heartbeat – Fainting Spells – Leg Swelling
- Nausea – Vomiting – Diarrhea – Constipation – Bowel Accidents
- Urinary Frequent / Urgency / Accidents – Frequent Urinary Infections – Erectile Dysfunction
- Anemia – Bruising Tendency – Bleeding Tendency
- Excessive Thirst – Excessive Hunger – Cold Intolerance – Heat Intolerance
- Chemotherapy – Radiation Therapy – Recurrent Fevers – Recurrent Infections – Organ Transplant
- Back Pain – Neck Pain – Joint Pain – Muscle Aches – Muscle Cramps – Muscle Weakness – Difficulty Walking
- Rash – Itching – Dry Skin – Worrisome Skin Lesions
- Abnormal Balance – Confusion – Numbness / Tingling – Dizziness – Headache – Loss of Coordination – Memory Loss – Seizures – Tremors
- Anxiety – Depression – Hallucinations – Changes in Behavior and/or Personality – Irritability – Sleep Disturbance– Substance Abuse

Personal Medical History: Do you have a history of any of the following medical problems? Please circle.

Heart Disease	Stomach Ulcers	Parkinson's Disease
Chest Pain/Angina	Reflux (GERD)	Multiple Sclerosis
Pacemaker	Constipation	Dizziness/Fainting
High Blood Pressure	Thyroid Disease	Easy Bruising or Bleeding
High Cholesterol	Vision Problems	Incontinence: Urine/Stool
Asthma	Hearing Loss	Anxiety/Depression
Sleep Apnea (Use CPAP/BiPAP)	Headaches/Migraines	Nipple Discharge
Shortness of Breath	Seizures/Epilepsy	Other:
Diabetes	Stroke/Brain Hemorrhage	_________________________
Cancer (type?)___________	Alzheimer's/Memory Loss	_________________________
Hepatitis	Brain Tumor	_________________________
Kidney Disease	Aneurysm	_________________________

Patient's Name ____ Today's date________________________________

Personal Surgical History: Please list any previous surgeries (year?) – or – circle "NONE" if applicable.

____ ______________________________________ ____________________________________

____ ______________________________________ ____________________________________

____ ______________________________________ ____________________________________

Medications: Please list ALL medications you take. Include prescription medicines, over-the-counter medicines, vitamins, birth control pills, hormones, vitamins, and dietary supplements.

____ ______________________________________ ____________________________________

____ ______________________________________ ____________________________________

____ ______________________________________ ____________________________________

Allergies: Please list ALL allergies/sensitivities to medications, iodine, shellfish, latex, or tape –or- Circle "NKDA" (No Known Drug Allergies)

____ ______________________________________ ____________________________________

____ ______________________________________ ____________________________________

____ ______________________________________ ____________________________________

Family History (what health problems run in your family? If family members are deceased state, age of death and cause of death if known):

Mother: ____ Maternal Grandmother:___________________________

Father:____ Paternal Grandmother:____________________________

Sister(s):____ Maternal Grandfather:____________________________

Brother(s):_______________________________________ Paternal Grandfather:_____________________________

Female Patients Only:

Are you pregnant?	Yes	No	Due Date:___________________________________
Have your periods stopped?	Yes	No	When?_______________________________________
Have you had a hysterectomy?	Yes	No	When?_______________________________________

Lifestyle/Social

Tobacco: Current/Past/Never

Cigarettes/Chew/Cigar/Pipe How much?______________________ How long?___________________ Quit date?__________________

Alcohol: Current/Past/Never

Beer/Wine/Hard Liquor Avg # drinks per week? __________ How long?___________________ Quit date?__________________

Please explain any treatment for substance abuse/alcoholism?____

Work/Home Information

What is your current living situation?____

Are you working now? Yes Job Title:____

How long have you done this job?____

No How long have you been off work?____

What work have you done in the past?____

____ ____

Patient Signature Physician's Signature/Date

Date: ___________________________

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Patient Registration Form - WESTERN NEURO

Please Complete All Fields

PATIENT INFORMATION

Patient's Name:[Last]_______________ [First]_______________ [Middle]____
Responsible Party (if not self):_______________
Patient Email: _______________

Residing Address:_______________ City:__________ State:______ Zip:______

Mailing Address:_______________ City:__________ State:______ Zip:______

Home Phone:__________ Cell Phone:__________ Work Phone:__________ Ext:______

Primary Care Physician:_______________ Phone#:__________ Fax#:__________

Referring Physician:_______________ Phone#:__________ Fax#:__________

Sex: ☐ Male ☐ Female Date of Birth:___/___/___ Social Security No:_____-_____-____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Other

Occupation: ☐Employed ☐Full-Time Student ☐Part-Student ☐ Retired ☐Unemployed

Employer/School:[Name]_______________ [Phone]__________

Spouse's:[Name]_______________ [Phone]__________

Emergency Contact:[Full Name]_______________ [Phone]__________

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name:_______________

ID#:_______________ Grp#:__________

Claims POBox:__________ Zip:__________
PolicyHolder Is (circle): Self Spouse Child Other:____

Policy Holder Name:__________ DOB:__________

Policy Holder's Employer:_______________

Policy Holder's SSN:_____-_____-__________

SECONDARY INSURANCE

Insurance Name:_______________

ID#:_______________ Grp#:__________

Claims POBox:__________ Zip:__________
PolicyHolder Is (circle): Self Spouse Child Other:____

Policy Holder Name:__________ DOB:__________

Policy Holder's Employer:_______________

Policy Holder's SSN:_____-_____-__________

INDUSTRIAL/WORKERS COMPENSATION

Carrier Name:_______________ Claim#:__________ Date of Injury:__________

Claims Billing Address:_______________ City:__________ State:______ Zip:______

Employer at Time of Injury:__________ Adjuster Name:__________ Ph#:__________

RELEASE OF MEDICAL RECORDS AND ASSIGNMENTS OF BENEFIT

I hereby authorize the Physicians of Western Neurosurgery Ltd. to release any information acquired in the course of my examination or treatment to my insurance company, HMO, AHCCCS (AZ Health Care Cost Containment Systems) hospitals, or referring Physician's office. I authorize the assignment of benefits and payment directly to Western Neurosurgery Ltd. and agree to pay any and all charges that exceed or that are not covered by insurance, including an attorney and collection fees incurred for collection purposes. Photo copy of this release and assignment is valid as the original.

Signature:_______________ Date:__________
**Relation to patient if above signature is not patient's:_______________

Revised March 2018

Notice of Office Privacy Practices- WESTERN NEURO

Please Complete All Fields

Patient Privacy: Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice; however, we would like your acknowledgement that you have been notified that the practice has a Notice of Privacy Practices.

Health Insurance Portability and Accountability Act

Please list the names of all individuals you would like to be able to receive and/or discuss your medical information with our practice. This authorizes us to leave messages concerning appointments, lab results, and release information concerning your health, to the individuals at the numbers you list on this form.

NAME / RELATIONSHIP PHONE

____

____

____

____

The Health Information Technology for Economic and Clinical Health Act

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17 2009, to promote the adoption of Meaningful Use for health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions, and strengthen the civil and criminal enforcement of the Health Insurance Portability and Accountability Act (HIPAA).

In order to comply with the above act, Western Neurosurgery, LTD. is required to obtain specific documentation for your electronic medical record.

Ethnicity (Please circle one):

LATINO/HISPANIC NON- LATINO/HISPANIC

Race (Please circle one):

AMERICAN INDIAN/ALASKA NATIVE
ASIAN
BLACK OR AFRICAN AMERICAN
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
WHITE
DECLINED / OTHER: ______________________

Please sign and date to indicate that you have read and understand the information provided on our office's privacy practices, and that our office has permission to contact the individuals you listed to receive and/or discuss your medical information with our practice.

Patient's Name:______________________________

Signature:____________________________ Date:________________________________

**Relation to patient if above signature is not patient's:___________________________________

Revised March 2018

Patient Responsibility Policy- WESTERN NEURO

Please Complete All Fields

PATIENTS ARE RESPONSIBLE **FOR CHECKING WITH THEIR CURRENT INSURANCE COMPANY** TO VERIFY COVERAGE AND CONTRACT INFORMATION. We are not contracted with all insurance plans.
FEES: We must comply with insurance company regulations, consequently our fees are fixed. If your insurance DOES NOT PAY 100% of our contracted fee, **you are responsible for your account balance prior to each visit**. If we are NOT contracted with your insurance plan, payment is expected at the time the service is rendered.
CO-PAYS: **All co-pays are collected when you arrive for your appointment. If you are not prepared to make your co-pay at the time of service, your appointment will be rescheduled.**
SELF PAY: If you will be paying for the visit out of pocket, the doctors require payment at the time service is rendered.
PATIENT BALANCE: ALL ACCOUNT BALANCES, AFTER INSURANCE HAS BEEN PROCESSED, **ARE DUE IN FULL WITHIN 30 DAYS**.
COLLECTIONS: Any patient that has been placed in COLLECTIONS must pay any prior balance owed to the practice as well as the collection agency fee PRIOR to being seen again.

Please sign and date below to indicate that you have read and understand the patient's financial responsibility outlined above.

Signature:____Date:________________

**Relation to patient if above signature is not patient's:____

PHARMACY INFORMATION

Please provide your pharmacy information:

Prescription refills are provided only for medications prescribed by Western Neurosurgery, LTD physicians. If you need a refill, please call your pharmacy. If your prescription is a narcotic, please call our office 72 hours prior to running out of your prescription. Patients are responsible for picking up prescriptions from Western Neurosurgery, LTD during normal business hours.

Your Name:____

Pharmacy Name:____

Pharmacy Phone Number:______________________Fax:________________

Pharmacy Address:____

Please sign and date below to indicate that you have read and understand the prescription refill policy.

Patient's Name:____

Signature:____Date:_____________________

**Relation to patient if above signature is not patient's:____

Revised March 2018