ONE BRAIN & SPINE CENTER℠

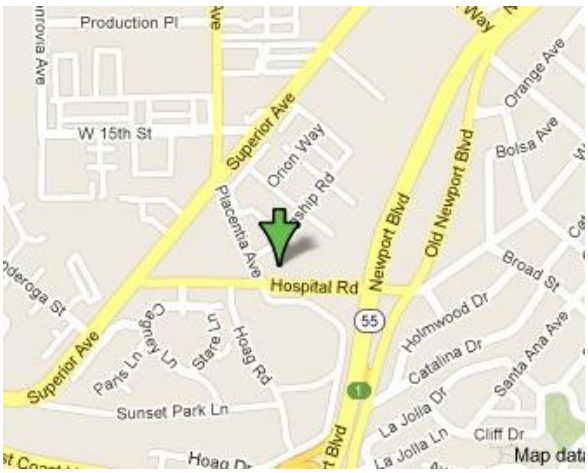
ORTHOPAEDIC SURGERY | NEUROSURGERY | EXCELLENCE

You may print and complete these forms, or complete the forms and then print and sign..

To allow a thorough review please be sure you have included:

A copy of your insurance card, front and back.
A copy of your **Imaging or Diagnostic Reports**
A copy of any other medical records you may have.

Please **BRING ALL FILMS/CDs** with you for your appointment. Thank you for your patience.



Office Location (map):
ONE Brain & Spine Center
361 Hospital Rd Suite 224
Newport Beach, CA 92663
Phone: (949) 383-4190

Please fax this document to (949) 612-7296
or scan and email to info@onebsc.com
Thank You.

PRELIMINARY PATIENT APPOINTMENT/HISTORY/REGISTRATION SHEET

Physician: **Robert Louis, MD** **DATE:**_____/_____/_____

PATIENT NAME: _____
LAST FIRST

HOME ADDRESS: _____
STREET CITY STATE ZIPCODE

HOME PHONE: (_____)_____-_____ **FAX#:** (_____)_____-_____
WORK PHONE: (_____)_____-_____
CELL PHONE: (_____)_____-_____ **EMAIL:** _____

DATE OF BIRTH:_____ **SS#:**_____

SEX: ☐ **MALE** ☐ **FEMALE**

EMERGENCY CONTACT: _____ **PHONE:** (_____)_____-_____
NAME RELATION

PHYSICIAN INFORMATION

REFERRING PHYSICIAN

PHYSICIAN NAME: _____ **SPECIALTY:**_____
LAST FIRST

PHYSICIAN ADDRESS: _____
STREET CITY STATE ZIPCODE

PHONE: (_____)_____-_____ ***FAX:** (_____)_____-_____

INTERNIST/PRIMARY CARE PHYSICIAN

PHYSICIAN NAME: _____
LAST FIRST

PHYSICIAN ADDRESS: _____
STREET CITY STATE ZIPCODE

PHONE: (_____)_____-_____ ***FAX:** (_____)_____-_____

OTHER PHYSICIAN

PHYSICIAN NAME: _____ **SPECIALTY:**_____
LAST FIRST

PHYSICIAN ADDRESS: _____
STREET CITY STATE ZIPCODE

PHONE: (_____)_____-_____ ***FAX:** (_____)_____-_____

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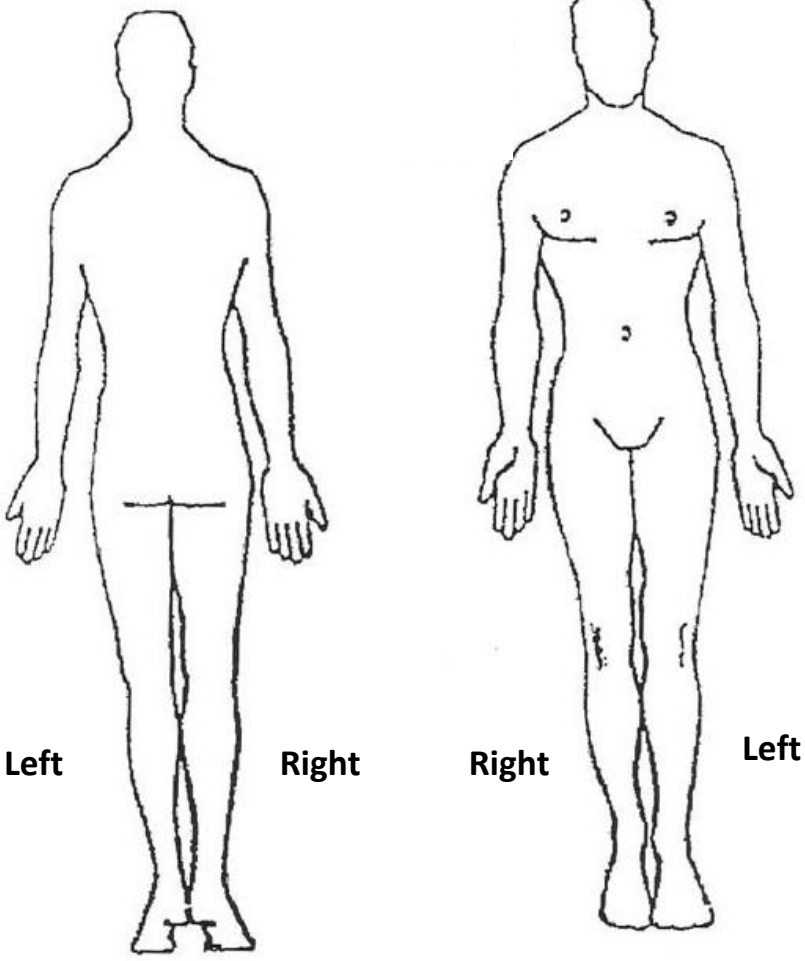
PAIN DESCRIPTION

Where is your pain right now?

Mark the areas on the body below where you feel the described sensations, using the appropriate symbols.
Mark the areas of radiation, including all affected areas.



Ache ^^^^^ ^^^^^

Numbness OOOO OOOO

Pins & Needles ■■■■ ■■■■

Burning XXXX XXXX

Radiating Pain ////// //////

HOW BAD IS YOUR PAIN RIGHT NOW? (PLEASE CIRCLE)

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

NO PAIN **INTERMEDIATE PAIN** **WORST PAIN**

HEIGHT:_____ WEIGHT:_____ BLOOD PRESSURE (IF KNOWN):_____/_____

NAME (PRINTED):_____ DATE:_____

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PATIENT HISTORY

PATIENT NAME:_____ **AGE:**_____ **DATE:**____/____/____
LAST FIRST

REFERRED BY: _____ **OCCUPATION:** _____

1. **WHEN DID SYMPTOMS FIRST START?**_____ **ARE THEY GETTING:** ☐ WORSE ☐ BETTER ☐ STABLE

2. **PLEASE DESCRIBE PRESENT SYMPTOMS:**_____

3. **WHAT POSITION/ ACTIVITY IMPROVES YOUR PAIN?** _____

4. **WHAT POSITION/ ACTIVITY WORSENS YOUR PAIN?** _____

5. **PLEASE SELECT ALL PRIOR TREATMENTS:**

   ☐ PHYSICAL THERAPY ☐ CHIROPRACTOR ☐ INJECTIONS ☐ MEDICATIONS ☐ ACUPUNCTURE

   ☐ PAIN MANAGEMENT ☐ MASSAGE ☐ OTHER:_____

6. **HAVE YOU HAD ANY INJECTIONS? PLEASE LIST TYPE(S), DATE(S) AND RESULTS:**_____

7. **HAVE YOU HAD PRIOR SPINE SURGERY OR PROCEDURE? ☐YES ☐NO**
   PLEASE LIST TYPE(S) AND DATE(S): _____

8. **PLEASE LIST ANY <u>RECENT</u> TESTS RELATED TO YOUR PROBLEM AND DATE (MRI, X-RAY, EMG, ETC.):**_____

9. **PLEASE LIST PREVIOUS DIAGNOSIS AND TREATMENTS/SURGERY RECOMMENDED:**_____

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10. PAST MEDICAL HISTORY: (PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD):

HYPTERTENSION	HIGH CHOLESTEROL	ASTHMA
DIABETES	DRUG/ALCOHOL ABUSE	GOUT
HEART DISEASE	BLEEDING/CLOTTING DISORDER	HIV
ATRIAL FIBRILATION	CANCER (TYPE:_____)	DEMENTIA
STROKE	HEPATITIS	CHRONIC INFECTIONS
SEIZURES	RADIATION/CHEMOTHERAPY	RESPIRATORY PROBLEMS
MULTIPLE SCLEROSIS	DEPRESSION OR	PARKINSON'S DISEASE
ULCERS	PSYCHOLOGICAL PROBLEMS	

11. PLEASE LIST ALL CURRENT MEDICAL PROBLEMS/CONDITIONS NOT LISTED:_____

_____

12. ALLERGIES: PLEASE LIST ALL DRUG OR FOOD ALLERGIES AND REACTION TO EACH:_____

_____

13. PLEASE LIST ANY OTHER PRIOR SURGERIES AND DATES:_____

_____

14. FAMILY MEDICAL HISTORY:

- **a. PLEASE DESCRIBE ANY FAMILY HISTORY OF SPINE PROBLEMS:**_____
- **b. PLEASE DESCRIBE FAMILY HISTORY OF OTHER MEDICAL PROBLEMS** : _____

_____

15. SOCIAL HISTORY:

- **a. DO YOU USE TOBACCO/SMOKE?_____IF SO, HOW MUCH OR LIST DATE YOU QUIT:**_____
- **b. ALCOHOL INTAKE?_____PLEASE LIST AMOUNT/FREQUENCY/TYPE**: _____
- **c. DESCRIBE PHYSICAL ACTIVITY/EXERCISE TYPE AND FREQUENCY:**_____

_____

- **d. VACCINES: WHICH HAVE YOU RECEIVED? INFLUENZA (YES/NO)?**_____ **PNEUMONIA (YEST/NO)?**_____

16. HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY):

FATIGUE	SHORTNESS OF BREATH	URINARY INCONTINENCE	DEPRESSION
FEVER	CHEST PAIN	WEAKNESS	ANXIETY
HEADACHE	CONSTIPATION	RASH	SUBSTANCE ABUSE
SLEEP DISTURBANCE	DIARRHEA	TINGLING/NUMBNESS	ALCOHOL ABUSE
ITCHING	NAUSEA	MEMORY LOSS	STRESS
BLURRED VISION	HEARTBURN	SEIZURES	NERVOUSNESS
HOT/COLD INTOLERANCE	VOMITING	BALANCE DIFFICULTY	MENTAL ILLNESS

OTHER (PLEASE DESCRIBE): _____

17. MEDICATIONS: PLEASE LIST ALL MEDICATIONS AND VITAMINS YOU ARE CURRENTLY TAKING AND THE DAILY DOSAGE :

MEDICATION	DOSAGE	FREQUENCY

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PATIENT CONSENT AND AUTHORIZATION

1. **Consent to Treatment**. I hereby authorize **{INSERT NAME}**., through its physicians and health care staff, to provide medical services to me, and I hereby consent to the performance of laboratory tests, diagnostic procedures, and other medical treatment as discussed with my health care provider. I also authorize **{INSERT NAME}**., to obtain outside medical and medication histories.

2. **Release of Information**. I hereby authorize **{INSERT NAME}**., to release and disclose all or any portion of my patient records to any person or entity which is or may be responsible for all or part of the charges for services rendered to me (including, but not limited to, insurers, employers and health care service plans) for the purposes of obtaining payment. I also authorize the release of patient information to other health care providers for purposes of diagnosis or treatment, and as may be required by law.

3. **Assignment of Benefits**. I hereby assign to **{INSERT NAME}**.,. and authorize payment directly to it of any and all health insurance or health plan benefits otherwise payable on my behalf or to me for services rendered. I understand and agree that I am financially responsible for any charges not paid by insurance benefits or otherwise not covered by this assignment and agree to pay the full cost of all such charges for services rendered.

4. **Health Care Service Plan Obligation**. I understand that **{INSERT NAME}**., participates on the panels of various health care service plans with which it contracts. If services rendered are found to be noncovered by a contracted health care service plan, or if I am not eligible to receive services by a contracted health care service plan, I agree to be individually obligated to pay the full cost of the services rendered to me by **{INSERT NAME}**.,

5. **Financial Agreement**. I hereby agree that I am individually obligated to pay all charges for services rendered to me that are not paid by insurance benefits or covered by a health care service plan (including, but not limited to, coinsurance, copayments and deductibles). I accept full financial responsibility for all such charges billed and guarantee to pay all such charges. All accounts are due and payable upon presentation of a statement. I understand that if any bill remains unpaid thirty (30) days after the statement date, interest will accrue at a rate of one percent (1%) per month on the unpaid balance. In the event that my account must be place with an attorney or collection agency to obtain payment, I further agree to pay all reasonable fees and collection expenses. I also agree that if my insurance plan pays my benefits directly to me, I will immediately send a check in the amount of the benefits paid to **{INSERT NAME}**.,

I hereby certify that I have read, understand and accept the above terms and conditions.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date

If patient is a minor or unable to consent

_____	_____	_____	_____
Name of Legal Representative	Signature of Legal Representative	Relationship to Patient	Date

Witness: _____ Date: _____