Metropolitan Neurosurgery, PA
Patient Registration Form

Patient Name_____ Birthdate_____
Last First MI

Address_____
Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____ Social Security # _____-_____-_____

Referred by_____ Primary Doctor_____

Race: White Asian Black or African American Hispanic Other_____

Marital Status: S M D W Separated___ Spouse Name_____ Preferred Language_____

Emergency Contact_____ Relationship_____ Phone #_____

Responsible Party
(If Other Than Above)

Name_____ Relationship_____
Last First MI

Birthdate _____ Social Security # _____ Employer _____ Work Phone _____

Home Address _____ Home Phone _____
Street City State Zip

Insurance Information

A copy of your insurance card will be taken at the time of your appointment.

Primary:
Health Auto Work Comp Liability (circle one)
Insurance Company Name_____
Address _____
Adjuster _____
Phone #_____ Date of Injury _____
Policy Holder _____
Claim or ID # _____
Group #_____

Secondary
Health Auto Work Comp Liability (circle one)
Insurance Company Name_____
Address _____
Phone # _____
Policy Holder _____
ID # _____ Group # _____

Attorney Information

Attorney Firm _____ Attorney Name _____
Address _____ Phone # _____

Assignment/Release of Information Authorization

I, the undersigned, hereby authorize payment of medical/surgical benefits directly to Metropolitan Neurosurgery, P.A. I authorize the release of my records to my insurance if required for claims submissions. I realize that all medical/surgical charges and accrued interest incurred by me, or my dependents, for services rendered at Metropolitan Neurosurgery, P.A. are my financial responsibility. If circumstances require the use of a third party collection agency, I understand that I will be responsible for payment of collections costs and/or attorney fees, if necessary. A photo copy of this original may be used in lieu of the original.

Signature _____ Relationship to Patient _____ Date _____

METROPOLITAN NEUROSURGERY, PA
PATIENT HEALTH HISTORY FORM

Today's Date: _____

PLEASE ANSWER ALL QUESTIONS:.

Patient Name: _____ Birth Date: _____ Weight: _____

Requesting Physician: _____ Family Doctor/Clinic: _____

Why are you seeing the doctor today? _____
Was this condition related to a WORK injury? YES NO
If yes, what date did the injury occur? _____
Was this condition related to an AUTO accident? YES NO
If yes, what was the date of the accident? _____
Was this related to any OTHER type of injury? YES NO What was the date of injury? _____
Describe the injury. _____
Have you been treated elsewhere for this condition? Yes NO
If yes, where? _____

Past Medical History:
List all previous hospitalizations or surgeries:

_____ Date: _____
_____ Date: _____
_____ Date: _____

List all Medical problems and Conditions that you have had or currently have:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Medications:
List any medications you are currently taking:

Name:	Dosage (Milligrams)	Frequency (# times per day)

INCLUDING OTC MEDICATION SUCH AS ASPIRIN OR VITAMIN E

Allergies:
Are you allergic to any medications? If yes list:

_____
Type of reaction: ___Rash ____Hives ____Severe Reaction ____ Intolerance ___ anaphlaxis ___ Other_____
ARE YOU ALLERGIC TO LATEX? _____

Health Habits:
Have you ever used tobacco YES NO If yes, how much? _____ Type: _____
If no longer use tobacco Stop Date _____
Do you drink alcohol? YES NO If yes, how much? _____
Have you ever used IV drugs? YES NO
Do you use herbs, vitamins or nutritional supplements? YES NO
If yes, please list: _____

PLEASE CIRCLE IF YOU HAVE A: DEFIBRILLATOR OR PACEMAKER

Family History:

Do you have a family history of arthritis or disease of the muscles, bones or nervous system? YES NO
If yes, please describe: _____

Do you have a family history of cancer? YES NO
If yes, please describe: _____

Do you have a family history of bleeding/clotting problems? YES NO
If yes, please describe: _____

Do you have a family history of any other diseases you would like your doctor to know about? YES NO
If yes, please describe: _____

Employment/Social History:

Are you currently employed? YES NO If yes, what is your occupation? _____
How long? _____ Employer: _____
Is your work ___Heavy ____ Medium ____ Light ____ Sedentary
Do you have any current work restrictions? YES NO
If yes, please describe: _____
What is your marital status?
(circle one) Single Married Widowed Divorced Separated
Who lives with you? _____ Pets? _____

Review of Systems:

Do you currently have any problems in the following areas? If yes, please provide additional information.

	YES	NO	Details
GENERAL (fever, heat stroke, wt loss/wt gain, fatigue, difficulty sleeping)			
EARS, NOSE, THROAT (hearing, sinus, earache, cough, dry mouth)			
EYES (vision problems, blind spots, glaucoma, eye pain)			
CARDIOVASCULAR (High BP, racing pulse, blood clots)			
RESPIRATORY (congestion, wheezing, shortness of breath, COPD)			
URINARY, KIDNEY, BLADDER (painful urination, frequency, incontinence, ect)			
MUSCLE, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, gout)			
DIGESTIVE (heart burn, nausea, indigestion, abdominal pain, bloating)			
SKIN (rashes, growths, warts, etc)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, thyroid, etc)			
BLOOD/LYMPH (bleeding, enlarged lymph nodes, blood transfusions)			
ALLERGIC/IMMUNE (sneezing, swelling, redness, itching, hives, lupus, etc)			

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____