Tomaszek Neurosurgical Associates
David E. Tomaszek, M.D.
P: (936) 321-1130 F: (936) 321-1170

NEW PATIENT REGISTRATION

Name (*First, M.I., Last)*: _____

Date of Birth: _____ Social Security #: _____ Sex: Male / Female

Address: _____

City:_____ State:_____

Preferred Phone Number: _____

Driver's License #:_____ Marital Status: _____

Employer: _____ Phone: _____

Referring Physician: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Phone Number: _____

Address: _____

Group # :_____ Member ID:_____ _____

Insured's Name: _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: _____ Phone Number: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Phone Number: _____

Address: _____

Group # :_____ Member ID:_____ _____

Insured's Name: _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: _____ Phone Number: _____

I authorize my physician to release any information to my insurance company or agency for services provided and reported. I also authorize payment of medical benefits to be directly to the physician provider for services rendered. I understand I am financially responsible for charges that are not covered by this authorization.

_____ _____

Patient Signature Date

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Name:_____

Today's Date: _____ Date of Birth: _____

What is the reason for your office visit? _____

Date of onset of symptoms? _____

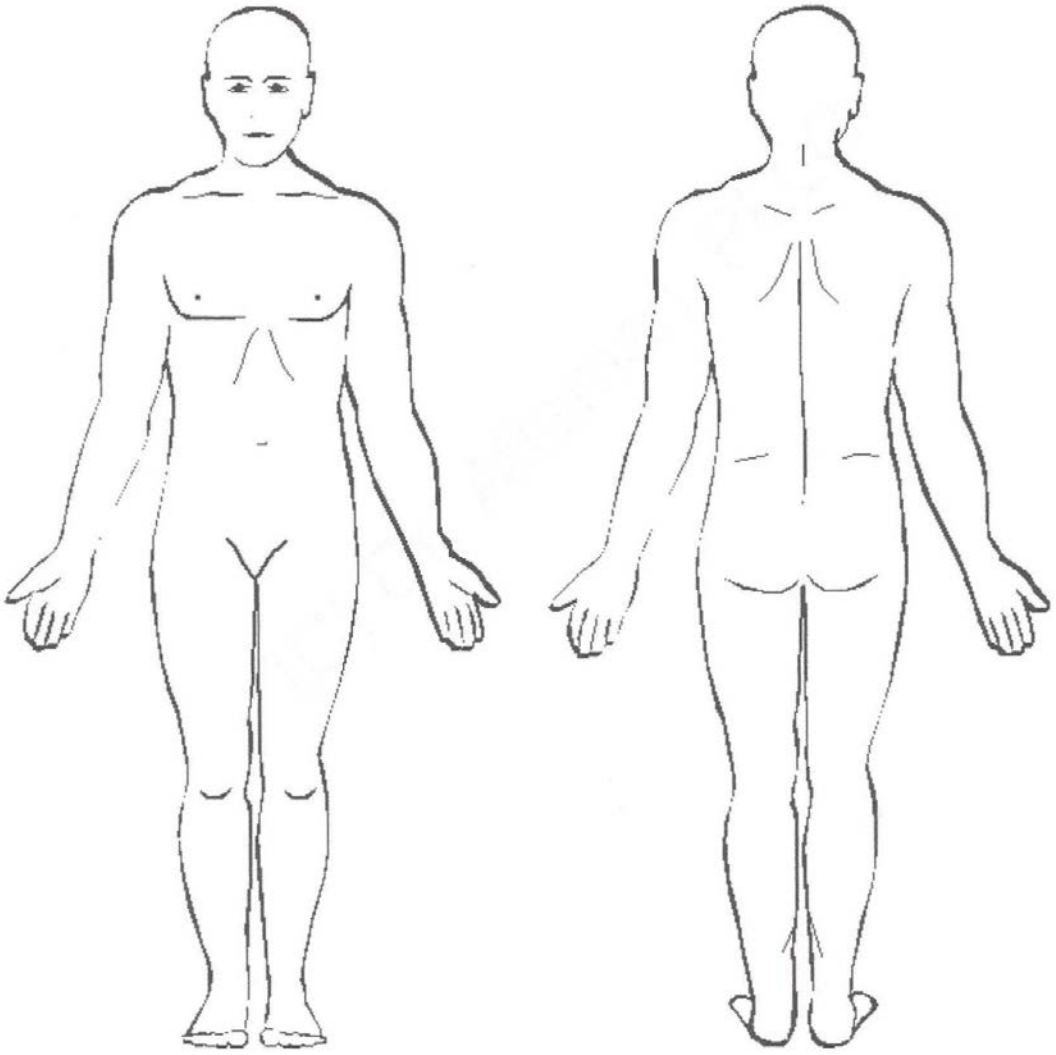
Directions: Mark these drawings according to where you hurt (if the right side of your neck is hurting, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

PLEASE CIRCLE YOUR CURRENT PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

KEY

X X X X X Weakness

= = = = = Numbness



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MEDICAL HISTORY

Please tell us about any surgical procedures you have had in the past.

Previous Surgeries:	**Dates:**

Please tell us about any other medical issue you may have.

Medical Issue:	**Duration of Condition:**	**Treatment:**	**Dates of Treatment:**

Do you smoke? ☐ Yes ☐ No How many packs per day? _____ How many years? _____

Do you drink? ☐ Yes ☐ No How many drinks do you have on average per week? _____

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all Type of Exercise: _____

Do you have a history of…

High Blood Pressure: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No

Arthritis: ☐ Yes ☐ No

Cancer: ☐ Yes ☐ No

Stroke: ☐ Yes ☐ No

Heart Attack: ☐ Yes ☐ No

Heart/Blood Disease: ☐ Yes ☐ No

Osteoporosis: ☐ Yes ☐ No

Hepatitis: ☐ Yes ☐ No

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MEDICAL HISTORY CONTINUED

Please answer the following questions in regards to your current condition:

Able to perform daily housework activities? ☐ Yes ☐ Yes, only with help ☐ Not at all

Able to perform daily work activities? ☐ Yes ☐ Yes, only with help ☐ Not at all

Current stress level? ☐ No Stress ☐ Mild Stress ☐ Moderate Stress ☐ High Stress

Current sleep leve? ☐ Excellent ☐ Good ☐ Moderate ☐ Bad

Please list all known allergies.

Allergies to Medications:	**All other Allergies:**

Please list all medications you are currently taking. ☐ No medications are currently being taken.

Drug Name:	**Drug Dose:**	**Frequency:**	**Prescribing M.D.:**

Preferred Pharmacy:_____ **Phone:** _____

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TREATMENT HISTORY

When did your problem first occur: _____

Please check all treatments you have received for this problem:

☐ Medication	☐ Physical Therapy	☐ Spinal Stimulation
☐ Injections or Nerve Blocks	☐ Chiropractic Treatment	☐ Acupuncture
☐ Surgery	☐ Massage	☐ Other

Please list the names and phone numbers of physicians you have seen:

_____

_____

_____

_____

_____

Please list all diagnostic tests you have had for your current illness:

Test	**Date**	**Hospital/Clinic**	**Additional Information**
X-RAY	_____	_____	_____
CT (CAT scan)	_____	_____	_____
MRI	_____	_____	_____
EMG	_____	_____	_____
Myelogram	_____	_____	_____
Other Tests	_____	_____	_____

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RELEASE OF INFORMATION

To Whom It May Concern:

I _____ authorize the staff of Tomaszek Neurosurgical Associates to discuss my medical history/condition with the following person(s).

(Name)	(Relationship)	(Phone Number)

_____
Patient Name (Print)

_____
Patient Signature

_____
Witness

_____
Date

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

Name:_____

Date:_____ DOB:_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Please check one of the following:

☐ I request the following restrictions to the use or disclosure of my healthcare information:

_____

_____

_____

☐ No Restrictions

_____ _____

Patient Signature Date

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose health information. We encourage you to read it in full. You can find a complete copy of our Privacy Policy online, or our Front Desk can provide a copy upon request.

Our Notice of Privacy Practices is subject to change. If you have any questions regarding our Privacy Policy, do not hesitate to contact our office.

I acknowledge receipt of Tomaszek Neurosurgical's Notice of Privacy Practices.

Patient Name:_____ DOB:_____

Patient Signature:_____ Date:_____

Relationship to Patient:_____

Protected Health Information (PHI) Disclosure Record

In general, the HIPPA privacy rules give an individual the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications of PHI made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner:

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Check all that apply:

☐ Leave call back number only

☐ OK to leave message with call back number

☐ OK to leave detailed message

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FINANCIAL AGREEMENT

Name:_____

Date:_____ DOB:_____

In order to eliminate any potential misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convience, we accept cash, check, Visa, Mastercard, and Discover.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment and/or deductible at the time of service. This office has the policy to collect this co-payment and/or deductible when you arrive for your appointment.
- In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all service provided at Tomaszek Neurosurgical. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- You may request an estimate of the cost for the proposed services before the procedure is performed.

Minor Patients

For all services rendered to minor patients, we will look to the adult and/or guardian with custody accompanying the patient for payment.

I have read and understood the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____

Printed Name of the Patient

_____ _____

Signature of Patient or Responsible Party if a Minor **Date**