NEUROSURGERY ASSOCIATES REGISTRATION FORM **Date filled out:** _____

Last Name _____ **First**_____ **Middle** _____

Date of Birth _____ **Marital Status** _____ **Male** **Female**

Street Address_____ **Apt. No.**_____

City_____ **State** _____ **ZIP Code** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Circle: **Employed** **Retired** **Disabled** **Unemployed** **Current or Prior Occupation:** _____

By providing your email address, you will be automatically web enabled to use our secure Patient Portal

e-mail address _____

PRIMARY CARE PHYSICIAN

Physician's Name _____ **Practice Name** _____

Street Address _____ **Suite/Building number** _____

City_____ **State** _____ **ZIP Code** _____

Office phone number _____ **Office Fax Number** _____

REFERRING PROVIDER **(IF DIFFERENT THAN PRIMARY CARE PHYSICIAN)**

Physician's Name _____ **Practice Name** _____

Street Address _____ **Suite/Building number** _____

City_____ **State** _____ **ZIP Code** _____

Office phone number _____ **Office Fax Number** _____

EMPLOYER INFORMATION

Employer Name _____

Address _____ **City**_____ **State** _____ **ZIP Code** _____

WORKERS' COMPENSATION INFORMATION

Insurance Company _____ **Adjuster** _____

Phone number _____**Date of Injury** _____**Claim #** _____

INSURANCE INFORMATION **PLEASE PROVIDE INSURANCE CARDS AND PHOTO ID TO BE VERIFIED AND COPIED**

EMERGENCY CONTACT **Name** _____ **Relationship to Patient** _____

Street Address (if different than patient's) _____ **Apt. number** _____

City_____ **State** _____ **ZIP Code** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Pharmacy Name _____ **Phone number**_____

Address _____ **City** _____ **State** _____ **Zip Code** _____

COMPLETE LIST OF ALL MEDICATIONS (include vitamins, supplements & over the counter medications)
DOSAGE AND SCHEDULE INFORMATION NOT NECESSARY

NAME OF MEDICATION	If you are on any of the following blood thinning medications please circle.
	Coumadin Warfarin Xarelto
	Clopidogrel Aggrenox Plavix
	Pradaxa Lovenox Heparin
	Aspirin OTHER Please list below:
	Do you have ANY allergies to medications?
	If yes, please list:
	Do you have ANY food allergies?
	If yes, please list:
	DO YOU HAVE A LATEX ALLERGY? YES NO

**Are you currently or have you previously been under the care of a Cardiologist? YES NO
If yes, Cardiologist's Name: _____

PLEASE LIST ANY PRIOR SURGERIES BELOW

YEAR (IMPORTANT)	TYPE OF SURGERY	YEAR (IMPORTANT)	TYPE OF SURGERY

FAMILY HISTORY

Is your father alive? YES NO If not, approximate age and cause of death_____
Please circle ALL that apply:

DIABETES HYPERTENSION HEART DISEASE STROKE CANCER UNKNOWN HISTORY

Is your mother alive? YES NO If not, approximate age and cause of death_____
Please circle ALL that apply:

DIABETES HYPERTENSION HEART DISEASE STROKE CANCER UNKNOWN HISTORY

MARITAL STATUS _____ NAME OF SPOUSE/PARTNER _____

Do you have children? YES NO If yes, please list below:

Name	Age	Occupation	Telephone number

DO YOU SMOKE? YES FORMER NEVER IF YES, HOW MUCH? _____

DO YOU DRINK? YES NO IF YES, CIRCLE ONE: Infrequent Social Daily (1-2 per day) Heavy

VITAL SIGNS (TO BE FILLED OUT BY OFFICE STAFF)

HEIGHT (INCHES)_____ WEIGHT_____ BP _____ HR _____ RR_____

Please indicate YES or NO if you currently experience any of the following symptoms:

	YES	NO		YES	NO		YES	NO
BONES and JOINTS			**CANCER**			**HEMATOLOGIC**		
Arthritis			Please explain below:			Easy bruising		
Painful Joints						Nosebleeds (NOT due to injury)		
Polio						Poor blood clotting		
Swollen Joints						Swollen glands		
Back Pain						Unexplained fevers		
Neck Pain			**ENDOCRINE**			Chills		
			Always feel cold					
CHEST / HEART / LUNGS			Always feel Hot/Warm			**SKIN**		
Shortness of Breath			Always tired, sluggish			Changing mole		
Poor Exercise Tolerance			Diabetes			Rash		
Fluttering of Heart			Gout			Psoriasis		
Unusual Heartbeat			Goiter			Other skin problem		
Chest Pain			Night Sweats					
New cough of any kind			Overactive Thyroid			**NEUROLOGICAL**		
Coughing up Blood			Underactive Thyroid			Severe headaches		
High Blood Pressure			Nervousness			Blurred vision		
Angina			Marked Weight gain			Double vision		
Rheumatic Fever			Marked Weight loss			Dizziness		
Varicose Veins			Irregular Periods			Fainting spells		
Wheezing			Absent periods			Difficulty w/balance		
Prior Heart Attack			Milky discharge from Breasts			Poor muscle strength		
Heart Murmur			Change in Ring size			Arm weakness		
Enlarged Heart			Change in Hat size			Leg weakness		
Abnormal Chest X-Ray			Change in Shoe size			Light flashes		
Abnormal EKG						Difficulty hearing		
Asthma			**GASTROINTESTINAL**			Buzzing or ringing in ears		
Emphysema			Indigestion or Heartburn					
History of DVT			Vomiting			Difficulty swallowing		
History of PE			Abdominal pain/cramps			Persistent hoarseness		
			Abdominal swelling			Speech difficulty		
GENITOURINARY			Diarrhea			Seizures		
Blood in Urine			Change in bowel habits			Strokes		
Pain or Burning when passing urine			Passing blood w/bowel movements					
Difficulty Passing Urine			Black, tarry stools			**PSYCHIATRIC**		
Trouble Controlling Urine			Stomach or duodenal ulcer			Hospitalization for psychiatric problems		
Kidney Stones			Hepatitis			Severe depression		
Prostate Trouble			Cirrhosis of the Liver					
			Gallstones					
EARS			Hemorrhoids					
Ear Pain			Nausea					
Drainage from Ear								
Sinus Trouble								

We have begun to use an electronic medical record system to become compliant with federal regulations.

We apologize for asking the following questions. WE ARE REQUIRED TO DO SO BY FEDERAL LAW. We encourage you to check "Refuse to Report" if you are in any way uncomfortable answering them.

Race:

_____ **American Indian or Alaskan Native**
_____ **Asian**
_____ **Native Hawaiian or other Pacific Islander**
_____ **Black or African American**
_____ **White**
_____ **Hispanic**
_____ **Refuse to Report**

Ethnicity Categories

_____ **Hispanic or Latino**
(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of Race.)

_____ **Not Hispanic or Latino**

_____ **Refuse to Report**

What is your preferred language? _____

NEUROSURGERY ASSOCIATES
1 DAVOL SQUARE, SUITE 302
PROVIDENCE, RI 02903

401-453-3545
FAX 401-453-3533

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Patient Name _____ Date of Birth _____

FINANCIAL AGREEMENT AND WAIVER

I consent to the treatment necessary for the care of the above named patient. I authorize Neurosurgery Associates, to disclose/receive patient's health information to/from primary care physicians, health care providers, and health insurance companies if applicable. I allow facsimile transmittal of the medical records if necessary. I acknowledge full financial responsibility for services rendered. I understand that payment of charges incurred is due at the time of service unless other financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default on payment of the charges, by the insurance company or other responsible party. I further authorize and request that all insurance payments be made directly to Stephen Saris, M.D.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers and insurance companies who may be involved in that treatment directly and indirectly. This information may also be used to obtain payment from third-party payers, conduct normal healthcare operations such as quality assessments and physician certifications.

I have read, reviewed, and understand fully by my signature below, this written authorization. I have been given a copy of the Office Policy Procedures and understand a copy of the HIPAA Privacy Practices is available upon my request.

SIGNATURE _____ DATE _____

Relationship (if other than patient) _____