COAST NEUROSURGICAL ASSOCIATES

A MEDICAL GROUP

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DIPLOMATES AMERICAN BOARD OF NEUROLOGICAL SURGERY

FELLOWS OF THE AMERICAN COLLEGE OF SURGEONS

Patient Registration

New patient_____ Established patient, new insurance____ Update____

PATIENT INFORMATION

DATE OF BIRTH:________________ MALE:____ FEMALE:_____

Last Name:________________________ First Name:________________________ Middle initial:________

Street:________________________ City:____________ State:________ Zip:__________

Home Ph#:(______)____________Cell Ph#:(______)____________ SS#:________________ Drs.Lic#:__________

____Married ____Single ____Minor ____Divorced ____Other ______Widow # of Children:_________

E-Mail Address:____

Employer:____

Address:____

Occupation:____________________ Work Ph#:(______)____________

Reason for Visit/Chief Complaint:________________________________ Are________Right

Duration/Date of Onset:________________________________ You:________Left

RESPONSIBLE PARTY INFORMATION

Please check if "Same as Patient":____________

Last Name:________________________ First Name:________________________ Middle initial:________

Street:________________________ City:____________ State:________ Zip:__________

Home Ph#:(______)____________Cell Ph#:(______)____________ Date of Birth:______________ Drs.Lic#:__________

____Married ____Single ____Minor ____Divorced ____Other ______Widow # of Children:_________

E-Mail Address:____

Employer:____

Address:____

Occupation:____________________ Work Ph#:(______)____________

HEALTH PLAN INFORMATION

Primary Insurance Subscriber:__________________ Insurance Co:____________________________

Insurance address:____ Ins Ph#:(______)____________

Effective Date:______________ Group#______________ Plan:______________ **Date of Birth**

Policy#:____________________ Primary Insured SS#:____________________ **of Subscriber:**__________________

Secondary Insurance Subscriber:__________________ Insurance Co:____________________________

Insurance address:________________________________ Ins Ph#:(______)____________

Effective Date:______________ Group#______________ Plan:____________ Policy#:______________

REFERRED TO THIS OFFICE BY

Referred by:________________________ Phone:(_____)__________________

Primary Care Physician:________________________ Phone:(_____)__________________

EMERGENCY CONTACT PERSON OR CAREGIVER

Name____ Relation to Patient:________________

Cell Ph#:(______)____________Home Ph#:(______)______________Work Ph#:(______)______________

____________________ ______________ ________________________

Patient Signature/Guardian Date Interpreter Signature

COAST NEUROSURGICAL ASSOCIATES

INITIAL CLINICAL HISTORY & PHYSICAL FORM

Name:____Date of Birth:________________

PAST MEDICAL HISTORY

(Please check all conditions that you have or have had)

___None	___Depression	___Diabetes Mellitus	___Asthma	___Cancer:__________
___Heart Disease	___Bleeding Difficulties	___Insulin Dependent	___TB	(type/treatment)______
___High Blood Presssure	___Hepatitis	___Renal Failure	___Emphysema	___Other__________
___Stroke	___HIV	___Arrhythmias	___Arthritis	(specify)__________
			(type)________________	

PAST SURGICAL HISTORY

Type of Surgery/Year

1.______________________________ 3.______________________________

2.______________________________ 4.______________________________

MEDICATIONS

Pharmacy Name and Phone Number:______________________________

Medication	Dose/Number per day	Medication	Dose/Number per day
1		4.	
2.		5.	
3.		6.	

ALLERGIES.TYPE OF REACTION

___No known drug allergies

1.______________________ 3.______________________

2.______________________ 4.______________________

SOCIAL HISTORY

(Please check all that apply)

Tobacco use

___Never

___Cigarettes: per day___

packs per day___

___Quit smoking

when__________________

Drug Use

___Marijuana

___Cocaine

___Amphetamines

___Other__________

Alcohol Use

___None ___Socially

___Daily ___Heavy

___Have you ever been treated for alcoholism?

No / Yes

If yes, when____________

___Have you ever been treated for drug addiction?

No / Yes

If yes, when____________

I Currently live in:

___**alone**___**with family**

___a house___an apartment

___retirement facility

___a mobile home

Is this the result of an injury?

___Yes

___No

If yes, where?

___Home ___Work ___Auto ___Other

If yes, when?

____

EDUCATION

(Please mark the highest level)

___Grade School

___High School

___College

___Post Graduate

Employment:

Full________

Part________

Temp_______

Retired______

Disabled_____

REVIEW OF SYSTEMS

(Please circle any of the following you currently experience)

General
- ___Weight loss
- ___Weight gain
- ___Fever
- ___Fatigue

ENT
- ___Sore throat
- ___Hoarseness
- ___Ear ringing
- ___Hearing loss

Respiratory
- ___Wheezing
- ___Cough
- ___Shortness of breath

Eyes
- ___Blurred vision
- ___Double vision
- ___Macular degeneration
- ___Glaucoma/cataract

Other
- ___Dementia
- ___Alzheimer's
- ___Difficulty swallowing

Cardiovascular
- ___Chest pain
- ___Fainting
- ___Feet swelling
- ___Palpitations

Gastrointestinal
- ___Abdominal pain
- ___Nausea
- ___Vomiting
- ___Ulcers

Genitourinary
- ___Frequency
- ___Hesitancy
- ___Incontinence
- ___Painful urination

Neurological
- ___Headache/ Contusion
- ___Numbness
- ___Slurred speech
- ___Seizure

Pregnant
- ___Yes
- ___No

Date of Last Menstrual?

____

Musculoskeletal
- ___Joint swelling
- ___Joint redness
- ___Arthritis
- ___Gait problems

Psychologic
- ___Anxiety
- ___Depression
- ___Severe stress
- ___Panic

Endocrine
- ___Excess sweat
- ___Excess thirst
- ___Excess hot
- ___Excess cold

Hematologic/Lymphatic
- ___Bleeding tendencies
- ___Lymph node swelling
- ___Easy bruising

Menstrual Irregularity?
- ____Yes
- ____No