DIABLO NEUROSURGICAL
MEDICAL GROUP, INC.

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Date: _____

Patient name:_____ Sex: Male/Female
Last name, First MI

Date of Birth: _____ SS#_____ Marital Status: _____

Address:_____
(please include an apartment or unit number)

_____ _____ _____
City State Zip code

Home phone: _____ Cell: _____ Work: _____

Emergency contact: _____
name relationship phone number

Occupation: _____ Work status: FT/PT/RETIRED/NOT EMPLOYED
(PLEASE CIRCLE ONE)

Employer _____ Phone#_____

Address: _____

IF DEPENDENT:

Responsible Party: _____ DOB:_____

Relationship: _____ SS#: _____

Employer _____ Phone#_____

Address: _____

Insurance Carrier: _____ Subscriber/Dependent

Policy #: _____ Group #: _____

Secondary Insurance: _____ Subscriber/Dependent

Policy #: _____ Group #:_____

Primary Care Physician: _____Phone # _____

Address: _____

Referring Physician: _____Phone # _____

Address: _____

Is patient's condition related to employment (current or previous): YES/NO Date of injury: _____
Is patient's condition related to Motor Vehicle Accident: YES/NO Place of accident:_____
Is patient involved in litigation or has an attorney involved in case: YES/NO

ASSIGNMENT OF BENEFITS: I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER PLANS TO **DIABLO NEUROSURGICAL MEDICAL GROUP**. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.
I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Signed: _____ Date: _____

CONFIDENTIAL MEDICAL HISTORY

Name | DOB | Age | Date

Occupation | Marital Status | Birthplace

Education | High School Years: | College Years: | Post Grad Years:

Primary Care Doctor | Other Treating Physicians

Chief Complaint

Family Medical History: | Relationship (Mother, Brother, Aunt, etc...)

Cancer	Y / N		Stroke	Y / N		Comments:
Tuberculosis	Y / N		Epilepsy	Y / N		
Diabetes	Y / N		Psychiatric	Y / N		
Heart Disease	Y / N		Suicide	Y / N		
Hypertension	Y / N		Other	Y / N		

Medications: PLEASE COMPLETE ATTACHED MEDICATION LIST

PERSONAL HISTORY:

Measles	Y	N
German Measles	Y	N
Mumps	Y	N
Chicken Pox	Y	N
Whooping Cough	Y	N
Scarlet Fever	Y	N
Diphtheria	Y	N
Smallpox	Y	N
Pneumonia	Y	N
Gonorrhea or Syphilis	Y	N
AIDS/HIV	Y	N
Tuberculosis	Y	N
Gallbladder Disease	Y	N
Influenza	Y	N
Rheumatic Fever	Y	N
Skin Infections	Y	N
Polio or Meningitis	Y	N
Neuritis or Neuralgia	Y	N
Arthritis	Y	N
Bone or Joint Disease	Y	N
Bursitis, Sciatica or Lumbago	Y	N
Kidney Disease	Y	N
Bladder Disease	Y	N
Anemia	Y	N
Jaundice	Y	N
Nervous Disease/Breakdown	Y	N
Epilepsy	Y	N
Migraines	Y	N
Headaches	Y	N
Diabetes	Y	N
Heart Disease	Y	N
Cancer	Y	N
Hypertension	Y	N
Colitis/Bowel Disease	Y	N
Rectal Disease	Y	N
Hay Fever	Y	N
Asthma	Y	N
Food, Chemical or Drug Poisoning	Y	N

Any other disease

TRANSFUSIONS:

Blood	Y	N
Blood Products	Y	N

ALLERGIES:

Penicillin	Y	N
Sulfa	Y	N
Aspirin	Y	N
Codeine, Morphine, Opiates	Y	N
Other Drugs	Y	N
Foods	Y	N
Adhesive Tape	Y	N
Tetanus antitoxin or serum	Y	N
Iodides	Y	N
Shellfish	Y	N

INJURIES:

Broken or cracked bones	Y	N
Sprains	Y	N
Lacerations	Y	N
Dislocations	Y	N
Concussion or head injury	Y	N
Loss of consciousness	Y	N

SURGERY:

Tonsillectomy	Y	N
Appendectomy	Y	N
Other Operations	Y	N
Type		
Type		
Type		
Type		
Type		
Have you been advised to have Surgery which has not been done?	Y	N
Have you been hospitalized for other reasons?	Y	N

HABITS:

Do you drink alcohol?	Y	N
If yes, how much		
Do you smoke?	Y	N
Did you smoke previously?	Y	N
Packs/day?		
How many years?		
Have you ever used recreational drugs?	Y	N
Have you ever used IV drugs?	Y	N

Height
Weight now
Weight one year ago
Maximum weight
When?

REVIEW OF SYSTEMS:

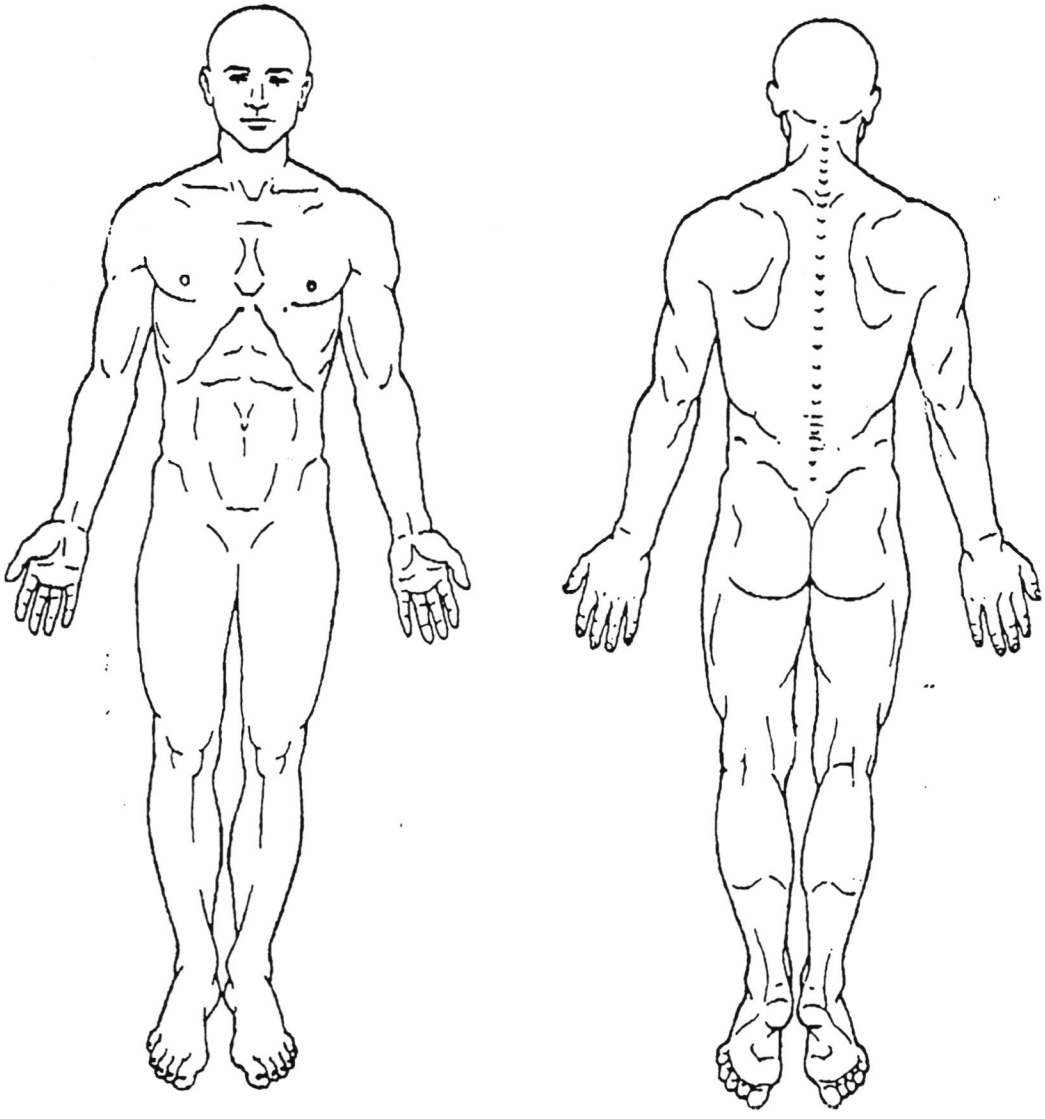
Frequent Headaches	Y	N
Loss of consciousness	Y	N
Vision changes	Y	N
Eye pain	Y	N
Do you wear glasses?	Y	N
Earaches	Y	N
Ringing in ears	Y	N
Hearing loss	Y	N
Nose bleeds	Y	N
Recurrent head colds	Y	N
Sinus problems	Y	N
Loss of taste or smell	Y	N
Persistent hoarseness	Y	N
Swallowing difficulty	Y	N
Chest pain	Y	N

PERSONAL HISTORY (CONT):

Palpitations	Y	N	Rectal pain with BM	Y	N
Shortness of breath	Y	N	Incontinence of stool	Y	N
Walking	Y	N	Difficulty urinating	Y	N
Climbing Stairs	Y	N	Increase/decrease in urination	Y	N
Lying down	Y	N	Incontinence of urine	Y	N
Chronic cough	Y	N	Brittle nails	Y	N
Night Sweats	Y	N	Dry skin	Y	N
Swelling of hands or feet	Y	N	Easy bruising	Y	N
Recurrent stomach pain	Y	N	Prolonged bleeding	Y	N

Please indicate on the drawing below where you experience your symptoms. Use the following symbols to indicate the nature of what you feel.

Numbness	000	Aching	===
Tingling	ttt	Cramping	ccc
Burning	xxx	Sensitive	sss
Stabbing	////	Other	ppp



Please rate your pain:

A: At its best

0 1 2 3 4 5 6 7 8 9 10

B: At its worst

0 1 2 3 4 5 6 7 8 9 10

0= no pain, 10= worst possible pain

DIABLO NEUROSURGICAL MEDICAL GROUP

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Diablo Neurosurgical Medical Group as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Please initial each section below then sign at the bottom*

Patient Financial Responsibilities

_____ As a courtesy to you, we will submit claims to your insurance company(s). However, you are required to provide us with the most correct and updated information about your insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

_____ Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service for co-payments. We accept Visa, Mastercard and debit cards as form of payment. **We do not accept cash or check payments in the office.**

_____ Patients may incur, and are responsible for the payment of additional charges at the discretion of Diablo Neurosurgical Medical Group. These charges may include charges for extensive forms completion and any costs associated with collection of patient balances.

_____ We do not provide services for medical conditions resulting from a work-related injury (WC) or auto accident or any other accident/injury involving a third party (TPL). It is your responsibility to ensure your physician is paid promptly regardless of pending disputed or litigated claims. If your private medical insurer denies payment or recoups payments previously made due to WC, Auto or other TPL, you will be responsible for the entire balance for services rendered.

_____ If you have no insurance coverage, we require payment for all charges at the time services are rendered.

Patient Authorizations

_____ I hereby authorize Diablo Neurosurgical Medical Group and the physicians, staff, and hospitals associated with Diablo Neurosurgical Medical Group to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company.

_____ I hereby authorize assignment of financial benefits and authorize payment of insurance benefits directly to Diablo Neurosurgical Medical Group for any and all services rendered. I understand that I am financially responsible for charges not covered by this assignment.

My signature below indicates that I have read and understood the foregoing information relative to my responsibility for services provided and agree to the provisions of this Patient Financial Responsibility Agreement.

_____ _____

Signature of Patient or Guardian Date

PATIENT HOME MEDICATION LIST

Please list **all medications** you are currently taking **including all of your over the counter, vitamin and herbal supplement**s. Please also include dosages and frequency.

Patient name: _____ Pharmacy: _____
Primary care MD: _____ Pharmacy ph.# _____

Medication/Supplement	Dosage	Frequency

Please list any medications you are allergic to AND the allergic reaction (ie: swelling, hives, breathing problems, itching, etc). If you have no allergies, please mark the box below:

☐ NO KNOWN DRUG ALLERGIES

Medication	Allergic reaction

Patient Signature: _____ Date: _____