Highlands Neurosurgery, PC

Located Inside Bristol Regional Medical Center

1 Medical Park Blvd., Suite 400 East
Bristol, TN 37620

423-844-5400

________________________________ has scheduled an appointment for you with

Dr. J. Travis Burt, Dr. Jody Helms, Dr. R. Andrew Rice, Dr. Matthew Wood or Dr. William Platt

on ____________________________________, 2020 at ______________.

To avoid any unnecessary delays, please arrive 30 minutes before your appointment time and bring the following with you on the day of your appointment:

*** Enclosed questionnaire, **completed**
*** X- rays **(films or CDs)** **<u>and</u> Radiologist's report**
Note: CDs (digital copies) will not be returned
*** Medical reports from treating physicians
*** First Report of Injury, IF work-related injury
*** Referral from insurance company, if required

If you have any questions, feel free to call (423) 844-5400.

Directions

Interstate I-81 to **Exit 74A**
Turn right at the first traffic light
We are in Bristol Regional Medical Center
East Office Plaza located beside short stay surgery.
Elevators to 4th floor
Directly off elevator
Suite 400 East

HIGHLANDS NEUROSURGERY
PATIENT INFORMATION

Patient's Name	Social Security Number	Marital Status	Sex	Birth Date	Age
Street Address	City /State/Zip			Home Phone	
Patient's Employer	Occupation or Student	How Long?	Work Phone	Cell Phone	
Employer's Address	City/State/Zip				
Spouse or Parent Name	Social Security Number			Birth Date	
Spouse's Employer and Address	City/State/Zip				
Referring Physician or Company	Address			Phone Number	
Family Doctor	Address			Phone Number	
Has any member of your immediate family been treated by our physicians? Y / N If so, please name:					
Emergency Contact Name	Emergency Contact Phone Number: Relationship:				
Primary Insurance Company	Insured			Relationship to Patient	
Policy Number	Group Number			Insured Employer	
Secondary Insurance Company	Insured			Relationship to Patient	
Policy Number	Group Number			Insured Employer	

Is your illness/injury due to an auto accident due to an auto accident Y / N
Is your illness/injury due to a work related injury Y / N
*** If you answered YES to either of the above questions, please fill out the appropriate information below:

Auto		**Work Comp**	
Date of Accident	Location of Accident	Date of Injury	Last Date Worked
How were you injured ?		How were you injured ?	
Auto Insurance	Insured's Name	Work Comp Carrier and Address	
Policy Number	Claim Number	Claim Number	
Fault of another party? Y / N		Do you have an attorney? [ ] Yes [ ] No	
Name and insurance company of liability insurer		Name Address Phone	
Claim Number	Policy Number		
Do you have an attorney? [ ] Yes [ ] No			
Name Address Phone			

Preferred Pharmacy

Pharmacy Name ________________________________

Street /City________________________________

MEDICAL HISTORY

Date_______________

Name ____ **Age** ______ **Birth date** ____________

Address ____ **Phone #** (___)_________

In order to be able to help with your problem, we need a complete detailed history; please complete this form fully. If you need more space please write on the back of the pages as needed.

Are you RIGHT_____ or LEFT_____ handed? Height _____________ Weight ______________

Family Doctor**:** ___________________________ Physician Requesting Consultation**:** _____________________________

CHIEF COMPLAINT: (in a few words summarize your problem):

____

____

____

____

____

HISTORY OF PRESENT ILLNESS: (give a detailed account of your problem starting form the onset; describe contributing factors and prior treatment if necessary):

____

____

____

PAIN ASSESSMENT: On a scale of 0 to 10 please rate your pain today (with "0" indicating no pain and 10 being the worst pain imaginable) ___________

SYSTEM REVIEW: (problems you have with other body parts or functions may be important to your neuralgic problem; please describe below any problems you may have with the following):

___ general well-being
___ weight loss
___ memory
___ vision
___ hearing
___ voice, speech
___ swallowing
___ abnormal neck swelling
___ shortness of breath
___ constipation
___ depression
___ ulcers
___ indigestion
___ diarrhea
___ blood in stool
___ bloating
___ hernia
___ joint pain or swelling
___ skin rashes
___ sexual dysfunction
___ seizures
___ loss of appetite
___ chest pain
___ abnormal heart beat
___ heart palpitations
___ anxiety
___ nervousness
___ arthritis
___ sleep disturbance
___ trouble with urination
___ stroke
___ infections
___ other ______________________

PAST HISTORY: (do you have or have you had any of the following and when?):

____________________ High blood pressure
____________________ Heart attack
____________________ Heart bypass surgery
____________________ Heart failure
____________________ Emphysema
____________________ Asthma
____________________ Blood vessel blockage
____________________ Seizures
____________________ Blood disorders
____________________ Brain hemorrhage
____________________ Blood transfusion
____________________ Tuberculosis
____________________ Diabetes mellitus
____________________ Cancer
____________________ Neurofibromatosis
____________________ Stroke
____________________ Aneurysm
____________________ Arthritis
____________________ Other _________________
____________________ Bleeding / clotting disorders
____________________ Brain Tumor

List SURGICAL PROCEDURES you have had (include invasive procedures such as angioplasty, colon polyps, cystoscopy, etc.)

____

____

Name: ____

List names and dosages of MEDICATIONS you take including non-prescription medicines:

Name	Strength	How Often

Are you ALLERGIC to any medications or drugs? No ___Yes ___(If yes list the drug name and type of reaction below):

____

____

SOCIAL HISTORY:
Occupation ______________________________________ ___________________________
Marital status _____________________
Tobacco use: yes ___ no ___ type _________ how long ________ how much per day _________________
Alcohol use: yes ___ no ___ how much _____________
Illicit drugs: ____________________________________
Have you traveled outside of the region, recently? Where _________________________ when _________
Highest level of education completed ______________________

FAMILY HISTORY: (do any of your blood kin relatives have a history of the following conditions and if so who?):

- ____________________ **High blood pressure**
- ____________________ **Heart attack**
- ____________________ **Heart bypass surgery**
- ____________________ **Heart failure**
- ____________________ **Emphysema**
- ____________________ **Asthma**
- ____________________ **Blood vessel blockage**
- ____________________ **Seizures**
- ____________________ **Blood disorders**
- ____________________ **Brain hemorrhage**
- ____________________ **Tuberculosis**
- ____________________ **Diabetes mellitus**
- ____________________ **Cancer**
- ____________________ **Neurofibromatosis**
- ____________________ **Stroke**
- ____________________ **Aneurysm**
- ____________________ **Arthritis**
- ____________________ **Other**
- ____________________ **Bleeding / clotting disorders**
- ____________________ **Brain Tumor**

Is there anything else about you that might affect your health or your response to medical treatment?

____

____

____

What doctors have you seen for this problem?

____

____

What tests have you had for this problem?

____

____

Patient signature ______________________________________

Physician signature _____________________________________

HIGHLANDS NEUROSURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Effective Date: September 20, 2013

I ________________________________ acknowledge that I have received a copy of Highlands Neurosurgery's **NOTICE OF PRIVACY PRACTICES.** This notice describes how Highlands Neurosurgery may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____ _____________

(Signature of Patient or Patient Representative) (Date)

____

(Relationship to Patient)

Any information pertaining to my medical and / or billing record may be given to the following individual(s):

Name	**Relationship**
____	_________________
____	_________________
____	_________________
____	_________________