

# Patient Registration Form



Patient Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)  
Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)  
Phone: (Primary) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Gender:  M  F SS #: \_\_\_\_\_

Insurance: \_\_\_\_\_ Patient Insurance ID Number: \_\_\_\_\_

Subscriber Name and Date of Birth: \_\_\_\_\_

Marital Status:  Single  Married  Widow/Widower  Divorced

Employment Status:  Full Time  Part Time Name of Employer: \_\_\_\_\_

Student Status:  Full Time  Part Time  NA School: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Race:  American Indian or Alaskan Native  White  Other: \_\_\_\_\_  
 African-American  Hispanic  
 Asian  Native Hawaiian

Ethnicity:  Hispanic or Latino  Non-Hispanic Language Spoken: \_\_\_\_\_

Drivers License # \_\_\_\_\_ State: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Name of Preferred Local Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please complete if PATIENT is a student or minor:

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

# TBSI OFFICE POLICIES

Welcome to TBSI Neurosurgery, part of the CHI St. Joseph Health Medical Neighborhood. Our practice is committed to providing comprehensive, patient-centered neurosurgical care to you and your family.

**Care Team Responsibilities:** We pride ourselves on providing you with team-based care in which each member of your care team fully utilizes their specific skills and abilities. Your care team may be comprised of physicians, physician assistants and office associates. While all are involved in your care in various ways, your neurosurgeon is the *leader* of your care team and is ultimately responsible for your treatment.

**Communication:** As a member of the CHI St. Joseph medical neighborhood, we work to coordinate your care across multiple settings, including primary care, other specialties and emergency medicine. Below are the communication processes you can expect from us:

- Your referring provider/primary care provider will be notified when your appointments have been scheduled and may be sent notes from your visit with us after your appointment.
- Many of your procedures, tests and prescribed medications are accessible by your care team in your electronic medical record.
- When you contact us via telephone or the web portal, we will respond to your questions as soon as possible. If your provider is not in the office, you will be notified of an expected response time given the provider's availability.
- We will release information ONLY to you, or to the individual you designated on the Medical Release of Information form.

These efforts are part of our mission to eliminate duplicate paperwork, unnecessary tests, and most importantly, provide the care you need, when you need it, and in a manner which you can understand.

**Our Expectations of Our Patients:** In order to allow us to provide you with the best possible care, it is important that you share your current contact information, your physical and mental health history, your medication lists, allergies as well as any social factors (living situation, relationship status, etc.) which may affect your physical, mental or emotional health. Please also provide the names and contact information of other providers you may be seeing in addition to your preferred pharmacy. This way, we can understand your health from a whole-person perspective. In the following sections you will find more information about our expectations from you as our patient.

## NEUROSURGERY BUSINESS HOURS

Monday – Friday from 8:00 a.m. – 5:00 p.m.

Closed 12:00 - 1:00 p.m. for lunch

**DISCLAIMER:** Scheduled surgeries may cause clinic schedules to run behind, resulting longer wait times and/or cancelled appointments. We will do our best to keep you updated to any potential schedule changes as we become aware of them. Thank you for your patience.

**After Hours Care:** You may call our office (979-776-8896) and will have the option to either leave a voicemail by dialing 0 once or be transferred to speak to our answering service by dialing 0 again. Should the nature of your call require a clinical assessment, the neurosurgery call team will be notified in order to render appropriate care. Please be advised, all emergency care will be rendered through the nearest emergency room. If your issue is non-emergent, you may leave a message and our staff will contact you the next business day.

**Urgent Care:** if you are experiencing any of the following symptoms, REPORT TO THE NEAREST EMERGENCY ROOM IMMEDIATELY.

- Chest pain, especially in men over 35 and women over 45.
- Shortness of breath
- Vomiting blood
- Stroke
- Fainting spells, especially in men over 35 and women over 45.
- Throat swelling from allergic reaction
- Unable to urinate
- CSF leak with severe headache
- Deep Vein Thrombosis
- Low or high blood pressure
- Temperature over 101.5

## Insurance and Payment

- We accept most forms of commercial and private insurance, as well as Medicare and Medicaid. However, it is a good idea to contact your insurance to ensure our providers are contracted with your specific plan to prevent any inconvenience or financial burden.
- If your insurance required you to have an authorization or referral from your primary care physician, our office must have received that prior to your office visit or we will be unable to see you that day.
- Uninsured patients are required to provide payment at the time of service.

## Arriving for Your Appointment

- **Please remember to bring your current insurance card, photo ID, any CDs that have imaging (x-rays, MRI, CT scans) and a current medication list to your appointment.** If you are **late** arriving for your appointment or are caused to be late by not completing your paperwork **prior to** your appointment time, **you may be rescheduled** to the next available appointment date and time.
- **Location of Appointment:** We have multiple locations, so please confirm the location of your appointment and plan for any travel related delays that may impact your arrival time.
  - For our Bryan location, please be sure to park in the patient parking, marked with blue lines. As we are located on the Texas A&M Health Science Center Campus, we are committed to keeping convenient parking available for our patients and therefore, have these spaces actively monitored to restrict usage by students. Patient parking is conveniently located in the first two rows in front of our building. Parking in an alternate location could result in a parking citation.
- **New patients:** Please arrive **30 minutes early** to your appointment to fill out new patient paperwork. If your paperwork is not completed **PRIOR** to your appointment time, you may be asked to reschedule your appointment out of respect for the other patients. Unless instructed differently, new patients will see the surgeon's Physician Assistant (PA). The PA participates in every aspect of your care, including the surgery if necessary, and will be your primary point of contact for clinical questions or concerns.
- **Established patients:** For your convenience, your appointment with your neurosurgical care team may/may not follow a corresponding appointment for imaging. Please be aware of your arrival time for each office as appropriate. TBSI Imaging is located on the first floor.
- **Cancellations/Reminders:** Please call at least 24 hours before your appointment if you need to cancel. TBSI does not maintain an active cancellation list. TBSI does not routinely make reminder calls for our patient's scheduled appointment times. Please call the office to confirm your appointment if you have any questions.
- **Treatment of Minors:** Patients under the age of 18 must be accompanied by a parent/guardian or have written permission for treatment from a parent/guardian if accompanied by another adult for every visit.
- **Dismissal from the Practice:** If you are "dismissed" from the practice, you can no longer schedule appointments, get medication refills, or consider any other doctors within St. Joseph Neurosurgery to be your doctor. Should you be dismissed, we will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. We will forward a copy of your medical records to your new doctor after you inform us and sign a release form.

## Acknowledgement of Notice of Privacy Practices

Patient Initials \_\_\_\_\_

I acknowledge that I have been provided a copy of the Notice of Privacy Practices of CHI St. Joseph Health, Bryan, Texas.

## Authorization to Inspect and Release Protected Health Information

Patient Initials \_\_\_\_\_

I authorize TBSI to release or acquire any medical information and/or medical records necessary to provide additional care such as evaluation, treatment and referrals.

For any other needs, TBSI will release information ONLY to you, or to the individual you designated on the Medical Release of Information form. This form is available on our website at [www.txbsi.com](http://www.txbsi.com) or at the front registration desk in our Bryan clinic.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Restriction: \_\_\_\_\_ Yes \_\_\_\_\_ No

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Restriction: \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list restrictions: \_\_\_\_\_

## Prescription and Medication Management

- **Prescriptions and Refills:** For refill requests, please contact your pharmacy at least 3 business days in advance of need. **DO NOT** wait until you have run out of medication. We do not fill any prescription refills after 5:00 pm, on weekends or during holidays.
- **Narcotic Prescriptions:** We **DO NOT** prescribe Schedule II medications (Hydrocodone or Norco, Vicodin, Vicoprofen, Lortab, Zydone) in the clinic.

**Please sign and date that you have read and understand our office policies.**

**Thank you.**

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

# Medical History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Medical History:** (Please check if you have or had any of the following)

<input type="checkbox"/> Abuse (physical/mental/sexual/verbal, etc.)	<input type="checkbox"/> Cholesterol (high)	<input type="checkbox"/> Intestinal Disease
<input type="checkbox"/> Abnormal Pap	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Kidney or Bladder Problems
<input type="checkbox"/> Alcoholism/Drug use	<input type="checkbox"/> Depression/mental disorder	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anxiety/nerves	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Serious Accident/Injury
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Genetic Diseases	<input type="checkbox"/> Sexual Disease/VD
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma/Cataract	<input type="checkbox"/> Stroke
<input type="checkbox"/> Allergies	<input type="checkbox"/> Gout	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bleeding disease	<input type="checkbox"/> Headaches/Migraine	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ulcers/Stomach Disease
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Hepatitis (any)	
<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> High blood pressure	

**Surgical History & Date / Age If Known:** \_\_\_\_\_ No Surgeries

Do you have an advanced directive on file? Yes No

**Hospitalizations:** \_\_\_\_\_ No Past Hospitalizations

Date/Age: \_\_\_\_\_ Reason: \_\_\_\_\_

Date/Age: \_\_\_\_\_ Reason: \_\_\_\_\_

**Family History:**

**History Of:**

<b>Father:</b>	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
<b>Mother:</b>	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
<b>Child:</b>	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
<b>Child:</b>	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
<b>Child:</b>	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown

**Social History:**

Tobacco Use: Yes No  Former  Never Drug Use: Yes No Alcohol Use: Yes No

Sexually Active: Yes No Ever had a Sexually Transmitted Disease? Yes No

**Social Functioning (Wellness exams only)**

During the past 4 weeks, was someone available if you needed and wanted help? For example, if you felt very nervous, lonely, or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.  Yes, as much as I wanted  Yes, quite a bit  Yes, some  Yes, a little  No, not at all  I choose not to answer

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Check all that apply)  Yes, it has kept me from medical appointments or getting my medications.  Yes, it has kept me from non-medical appointments, meetings, work, or getting things I need.  No.  I choose not to answer.

**Medications Currently Taking (List) Name / Dosage / How Often:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies:** to medications, food, or latex (List): \_\_\_\_\_

**FEMALES ONLY:** Is it possible that you may be pregnant? YES NO Date of Last Menstrual Cycle: \_\_\_\_\_

**Immunizations Up-To-Date?** \_\_\_ Current to my knowledge \_\_\_ Not up-to-date \_\_\_ Unknown (will discuss w/provider)

**Injured at Work:** YES NO Date/Time of Injury: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

# TBSI – Neurosurgery

## Overall Health Status:

I feel my overall state of health is:

Good

Fair

Poor

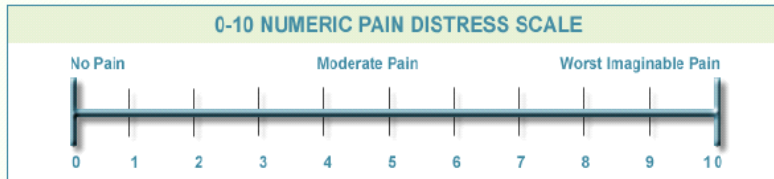
Height: \_\_\_\_\_

Weight: \_\_\_\_\_

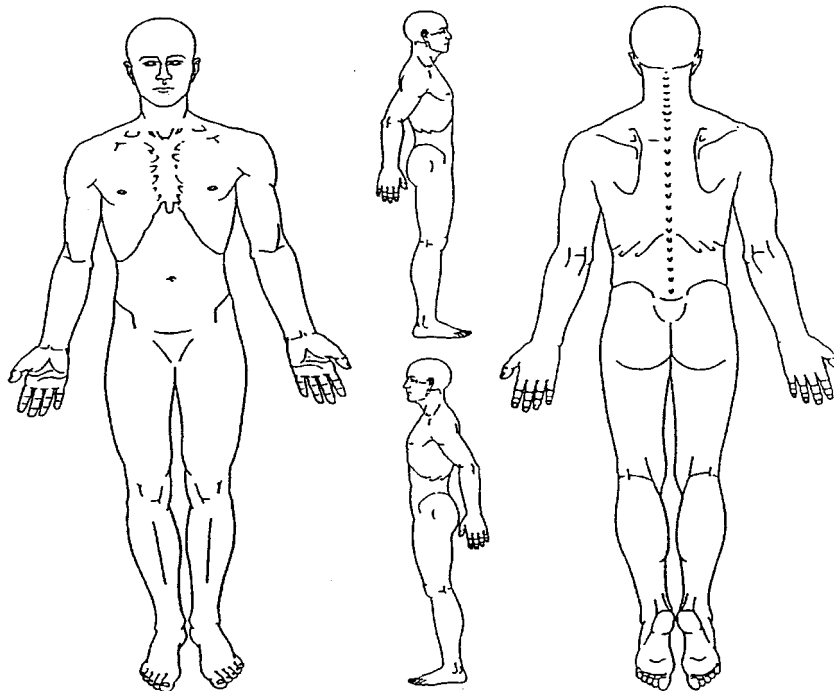
I am right-handed

I am left-handed

**Pain Scale:** Using the scale below, what number would you rate your **current** pain? \_\_\_\_\_



USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN		
<b>A = ACHE</b>	<b>B = BURNING</b>	<b>C = STABBING</b>
<b>N = NUMBING</b>	<b>P = PINS &amp; NEEDLES</b>	<b>O = OTHER</b>



1. My pain is in my: \_\_\_\_\_
2. Select one of the following:
  - My problem is chronic. It began at age: \_\_\_\_\_
  - My pain began (date and year): \_\_\_\_\_
3. Is this related to a recent injury?  Yes  No  Possibly  
 Is the injury work related?  Yes  No                      Date of injury? \_\_\_\_\_  
 Date stopped work? \_\_\_\_\_
4. Please explain how it happened: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

I also have the following problems:

- My pain awakens me from sleep
- My pain is worse at night
- I have numbness/tingling in my arms
- I have numbness/tingling in my hands
- I drop items after I pick them up
- I am off-balance when I walk
- I stumble/fall frequently or run into walls
- My arms/legs are weak because they hurt
- My legs feel weak or hurt when I walk too far:
  - This is relieved by sitting
  - This is relieved by stopping and standing
- I can walk:
  - Less than a block
  - 1-2 blocks
  - More than 3 blocks
- I awaken at night with my hands asleep
- My hands go to sleep while:
  - Driving
  - Using a computer mouse
  - Using a telephone or blow dryer
- I have weakness in my:
  - Right leg     Left leg
- I have numbness/tingling in my:
  - Right leg     Left leg
  - Right foot     Left foot
- I have trouble with my bladder control
  - Can't empty my bladder
  - Loss of control (accidents)
- I have trouble with my bowels
  - Constipation
  - Loss of control (accidents)

**Previous Treatment and Medication for This Condition:**

None

I have been prescribed for this condition:

With how much relief?

<input type="checkbox"/> Medications:	None	A Little	A Lot
<input type="checkbox"/> Anti-inflammatories: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscle relaxers: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain medication: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Steroid Dose Pack/Medrol/Prednisone: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Exercises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spinal Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Manipulation: Chiropractor's Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heat <input type="checkbox"/> Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name: \_\_\_\_\_

Date: \_\_\_\_\_

➤ I have seen other doctors for my condition:  Yes  No

If Yes, on what date? \_\_\_\_\_ By whom? \_\_\_\_\_ Where? \_\_\_\_\_

➤ I have had surgery before for this same type of problem. How long ago? \_\_\_\_\_

What type of surgery? \_\_\_\_\_ Physician who performed surgery? \_\_\_\_\_

➤ I have had the following tests:  Plain X-Rays  CAT Scan  MRI  
 Myelogram  Discogram  EMG

**The following actions make me feel:**

	<b>Better</b>	<b>Worse</b>		<b>Better</b>	<b>Worse</b>
Bed rest	<input type="checkbox"/>	<input type="checkbox"/>	Standing	<input type="checkbox"/>	<input type="checkbox"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>
Stretching/Popping	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>
Bending Backwards/Forwards	<input type="checkbox"/>	<input type="checkbox"/>	Heat	<input type="checkbox"/>	<input type="checkbox"/>
Bending to the left	<input type="checkbox"/>	<input type="checkbox"/>	Ice	<input type="checkbox"/>	<input type="checkbox"/>
Bending to the right	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing/Coughing	<input type="checkbox"/>	<input type="checkbox"/>
Straining to go to the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	Changing Positions	<input type="checkbox"/>	<input type="checkbox"/>

**Work Essentials:**

My job requirements are:

- I am not currently employed
  
- Heavy Lifting – over 60 lbs with frequent bending and stooping
- Medium Lifting – between 30-50 lbs
- Light Lifting – 10-20 lbs
  
- Sedentary – mostly sitting with very little lifting
- My job is highly stressful & it makes me tense