

# VANGUARD BRAIN & SPINE SPECIALISTS, P.A.

DATE: \_\_\_\_\_

ACCT #: \_\_\_\_\_

PLEASE PRINT AND FILL OUT FORM COMPLETELY

## PATIENT INFORMATION:

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

Name: \_\_\_\_\_  
First Name                      Nickname                      Middle Initial                      Last Name

Address: \_\_\_\_\_  
Street Address                      City and State                      Zip Code                      County

Home Phone #:( ) \_\_\_\_\_ Cell #:( ) \_\_\_\_\_ Social Security#: - -

Sex (circle) M F Date of Birth: \_\_\_\_\_ Primary Language \_\_\_\_\_ Marital Status (circle) S M W D Sep.

Work Hours: AM \_\_\_ PM \_\_\_ Patient's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Work Phone#:( ) \_\_\_\_\_ ext: \_\_\_\_\_

Responsible Party's Name (if a minor): \_\_\_\_\_ Social Security#: - -

Address: \_\_\_\_\_ Phone#:( ) \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Work#:( ) \_\_\_\_\_ ext: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Spouse's Work#:( ) \_\_\_\_\_ extension: \_\_\_\_\_ Work Hours: \_\_\_\_\_ AM PM

### Relative whom we can contact in the event of an emergency (not living with you)

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone#: \_\_\_\_\_ ext: \_\_\_\_\_

Doctor to see you today: \_\_\_\_\_

Referring Doctor (s): \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Were you injured on the job? (circle) Yes No If yes, Date of Injury: \_\_\_\_\_

Are you filing Worker's Compensation? Yes No Time of Injury: \_\_\_\_\_

Describe how the injury occurred: \_\_\_\_\_

Which Doctor saw you first? \_\_\_\_\_ City/State: \_\_\_\_\_

Case Worker: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Is this visit a result of auto accident or other injury? (circle) Yes No

If yes, Date of Injury: \_\_\_\_\_ Type of Injury: \_\_\_\_\_

If yes, please read, sign and date:

I am aware that Vanguard Brain & Spine Specialists, P.A. does not accept Third Party Liability. The charges/bills for services rendered to me by Vanguard Brain & Spine Specialists, P.A. are my financial responsibility.

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

PLEASE COMPLETE THE INSURANCE INFORMATION ON THE REVERSE SIDE OF THIS FORM

# INSURANCE INFORMATION

MEDICARE #: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

MEDICAID #: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

## PRIMARY INSURANCE COVERAGE:

Insured's Name: \_\_\_\_\_  
*Last Name* *First Name* *Middle Name*

Insured's Address: \_\_\_\_\_  
*Street Address* *City and State* *Zip Code* *County*

Insured's Date of Birth: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Patient's relationship to the Insured: (circle) Self Spouse Child Other

Insured's Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_\_ Insured's Policy or Group#: \_\_\_\_\_

Insured's Certificate#: \_\_\_\_\_ Is Pre-certification required for surgery? Yes No

## SECONDARY INSURANCE COVERAGE:

Insured's Name: \_\_\_\_\_  
*Last Name* *First Name* *Middle Name*

Insured's Address: \_\_\_\_\_  
*Street Address* *City and State* *Zip Code* *County*

Insured's Date of Birth: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Patient's relationship to the Insured: (circle) Self Spouse Child Other

Insured's Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_\_ Insured's Policy or Group#: \_\_\_\_\_

Insured's Certificate#: \_\_\_\_\_ Is Pre-certification required for surgery? Yes No

**PLEASE PRESENT YOUR INSURANCE CARDS AND DRIVER'S LICENSE TO THE WINDOW WHEN YOU HAVE COMPLETED THIS FORM AND SIGN BELOW.**

**THANK YOU!**

I plan to make payments of my medical expenses as follows: (circle one)

CASH \_\_\_\_\_ CHECK \_\_\_\_\_ VISA/MASTERCARD \_\_\_\_\_

I WILL NEED TO SPEAK TO SOMEONE REGARDING A PAYMENT PLAN \_\_\_\_\_

\*I hereby authorize Vanguard Brain & Spine Specialists, P.A. to release all information in the course of my examination or treatment for insurance claims.

\*I hereby authorize payment directly to Vanguard Brain & Spine Specialists, P.A. for any surgical and/or medical benefits otherwise payable to me for these services as described.

\* I understand that I am financially responsible for charges not covered by this authorization and agree to full payment on this account.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ACCT#: \_\_\_\_\_

FULL NAME: \_\_\_\_\_ FIRST NAME YOU GO BY: \_\_\_\_\_

AGE: \_\_\_\_\_ RIGHT-HANDED? \_\_\_\_\_ LEFT-HANDED? \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

*(Check if you have had any of the following or any other serious illness)*

HIGH BLOOD PRESSURE \_\_\_\_\_ HEART ATTACKS \_\_\_\_\_ STROKE \_\_\_\_\_ DIABETES \_\_\_\_\_

GASTROINTESTINAL SYMPTOMS *(including peptic ulcer disease and hiatal hernia)* \_\_\_\_\_

CANCER OR TUMORS *(specify where)* \_\_\_\_\_ LUNG DISEASE *(asthma, COPD, emphysema, etc.)* \_\_\_\_\_

OTHER \_\_\_\_\_

**FAMILY HISTORY:**

MOTHER-AGE \_\_\_\_\_ HEALTH STATUS \_\_\_\_\_ ILLNESSES \_\_\_\_\_

FATHER-AGE \_\_\_\_\_ HEALTH STATUS \_\_\_\_\_ ILLNESSES \_\_\_\_\_

MEDICAL PROBLEMS IN FAMILY? *(such as Diabetes, High Blood Pressure, Neurological Disease)* \_\_\_\_\_

Have you or anyone in your family been operated on by a physician in this practice?  Yes  No

**EXPLAIN IN DETAIL WHAT YOU ARE BEING SEEN FOR TODAY:**

*(symptoms, when did they begin, previous treatment)*

DATE YOU STARTED HAVING SYMPTOMS FOR THIS CONDITION: \_\_\_\_\_

ARE YOU EXPERIENCING PAIN IN THE FOLLOWING: *(If so, explain in detail)* ARM \_\_\_\_\_ NECK \_\_\_\_\_

LEG \_\_\_\_\_ BACK \_\_\_\_\_ WEAKNESS *(where)* \_\_\_\_\_

NUMBNESS OR TINGLING IN ANY PART OF YOUR BODY *(specify where)* \_\_\_\_\_

LOSS OF CONTROL OF BOWEL OR BLADDER? *(explain)* \_\_\_\_\_

HEADACHES? \_\_\_\_\_ CONVULSIONS OR SEIZURES? \_\_\_\_\_

LOSS OF CONSCIOUSNESS \_\_\_\_\_ OTHER \_\_\_\_\_

**LIST ANY AND ALL PREVIOUS OPERATIONS:**

DATE: \_\_\_\_\_ PROCEDURE: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

DATE: \_\_\_\_\_ PROCEDURE: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

DATE: \_\_\_\_\_ PROCEDURE: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

*(use the back if additional space is needed)*

**ARE YOU ALLERGIC TO ANY MEDICATION? *(If yes, please list) (use the back if additional space is needed)***

MEDICATION: \_\_\_\_\_ REACTION \_\_\_\_\_

MEDICATION: \_\_\_\_\_ REACTION \_\_\_\_\_

MEDICATION: \_\_\_\_\_ REACTION \_\_\_\_\_

DO YOU SMOKE? *(circle)* Y N , If yes, how much a day? \_\_\_\_\_ When did you start to smoke? \_\_\_\_\_

DO YOU DRINK ALCOHOLIC BEVERAGES *(circle)* Y N , If yes, socially \_\_\_\_\_ daily \_\_\_\_\_

DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE? *(circle)* Y N

RECENT WEIGHT GAIN OR LOSS? *(if yes, please explain)* \_\_\_\_\_

PRESENT HEIGHT \_\_\_\_\_ PRESENT WEIGHT \_\_\_\_\_

NAME \_\_\_\_\_

ACCT#: \_\_\_\_\_

Review of systems

Present weight: \_\_\_\_\_

Present height: \_\_\_\_\_

Are you currently having problems with: (circle if yes)

Constitutional

- Fever
- Weight loss
- Night Sweats

Eyes

- Wear glasses
- Infections
- Injuries
- Glaucoma
- Cataracts

Ear, Nose, Throat and Mouth

- Hearing aid
- Hearing loss
- Ear Pain
- Ringing in ears
- Balance disturbance
- Nosebleeds
- Nasal congestion/drainage
- Inability to smell
- Sinus problems
- Sinus headache
- Sore throat
- Mouth sores

Cardiovascular

- Chest pain/angina
- High blood pressure
- Irregular pulse
- Heart murmur
- High cholesterol
- Swelling in feet or hands
- Leg pain while walking

Respiratory

- Asthma
- Chronic cough
- Emphysema
- Shortness of breath

- Bronchitis

- Pneumonia

- Lung cancer

- Bloody sputum

- Date of last X-ray \_\_\_\_\_

- Date of last EKG \_\_\_\_\_

Gastrointestinal

- Indigestion or pain with eating
- Nausea
- Vomiting
- Blood in your vomit
- Ulcers or Gastritis
- Liver disease
- Jaundice
- Abdominal pain
- Change in your bowel habits
- Colon cancer

Genitourinary

- Urinary tract infections
- Painful urination
- Blood in your urine
- Difficulty starting or stopping stream
- Incontinence
- Kidney stones
- Prostate cancer (males)
- Endometriosis (females)
- Uterine or cervical cancers (female)

Musculoskeletal \_\_\_\_\_

- Broken bones - list
- Arm weakness
- Leg weakness
- Back pain
- Arm pain
- Leg pain
- Joint pain or swelling
- Arthritis
- Neck pain

Integumentary

- Skin disease
- Skin cancer
- Breast pain, tenderness or swelling
- Nipple discharge

Neurological

- Fainting spells or "Blacking Out"
- Seizures
- Problems with your memory
- Disorientation
- Difficulty with your speech
- Inability to concentrate
- Double or blurred vision
- Face weakness
- Coordination in arms and/or legs

Psychiatric

- Anxiety
- Depression
- Other Psychiatric disorder/treatment

Endocrine

- Diabetes
- Thyroid disease
- Increased appetite
- Excessive thirst or urination
- Hormone problems

Hematologic/Lymphatic

- Anemia
- Hemophilia
- Bleeding tendencies
- Persistent swollen glands or lymph nodes
- Blood transfusion, if yes, when? \_\_\_\_\_

Allergic/Immunologic

- Food allergies
- Inhalant (nasal) allergies
- Immunologic disorders

Please explain any circled item: \_\_\_\_\_

\_\_\_\_\_

(use the back if additional space is needed)

The above information is accurate to the best of my knowledge.

\_\_\_\_\_  
*Patient signature*

\_\_\_\_\_  
*date*

I have reviewed the above information with the patient.

\_\_\_\_\_  
*Physician signature*

\_\_\_\_\_  
*date*

**PLEASE RETURN THESE FORMS TO THE RECEPTIONIST. THIS WILL ALLEVIATE HAVING TO WAIT LONGER THAN NECESSARY TO SEE THE DOCTOR. THANK YOU!**

PLEASE COMPLETE THIS SHEET DENOTING ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND ANY YOU ARE ALLERGIC TO. IF YOU BROUGHT A COMPREHENSIVE LISTING WITH YOU, PLEASE ALLOW US TO COPY YOUR LIST.

NAME:

DATE:

ACCT#:

Name of Medication	Dosage	Frequency	Reason for Taking	For Office Use Only	
				Date Up Dated	Initials
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					

ALLERGIES AND REACTIONS:

VANGUARD BRAIN & SPINE SPECIALISTS

1130 N. Church St., Suite 200

Greensboro, NC 27401

Telephone: (336) 272-4578

Fax: (336) 272-5931

Authorization to Release Information

Patient: (Please Print) \_\_\_\_\_

DOB: \_\_\_\_\_ Account #: \_\_\_\_\_ SSN: \_\_\_\_\_

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

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

Relationship to Patient: \_\_\_\_\_

Witnessed By: \_\_\_\_\_ Date: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize Vanguard Brain & Spine Specialists to use the following protected information and/or disclose the following protected health information to: **(Please denote on second page.)**

Any information regarding my physical condition and treatment rendered (this includes information pertaining to my mental health, drug, alcohol abuse and HIV/AIDS diagnosis) and to allow them to furnish or fax any reports of any x-rays or records which they have regarding my condition and/or treatment.

This protected health information may be used or disclosed to the following: Transfer of care, attorney, insurance, other treating physicians, caregivers or myself. **(Please denote any exceptions you may have on the second page.)**

This authorization shall be in force and effective until one year from the date of signature at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by such written notification to Vanguard Brain & Spine Specialists at 1130 N. Church St., Greensboro, NC 27401. I understand that this does not apply to correspondence sent out prior to this date.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Vanguard Brain & Spine Specialists will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

Turn Page Over to Continue. . .

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under state or federal law.
- Refuse to sign this authorization.

**I request that my protected health information be sent to:**

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

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**List any exceptions to disclosure:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:**

You have the following rights with respect to your medical information:

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner as stated in our Privacy Policy.
- Generally, you may inspect your medical information and receive a copy. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies requested of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by Vanguard Brain and Spine Specialists following April 14, 2003, except for disclosures which you authorized and certain other specific disclosure types.
- You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

Vanguard Brain and Spine Specialists  
 ATTN: Amy Robson  
 1130 N. Church Street, Suite 200, Greensboro, NC 27401  
 Telephone: (336) 272-4578  
 Fax: (336) 272-5931

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact, as above, Amy Robson.

**THIS NOTICE IS EFFECTIVE AS OF APRIL 14, 2003**

**REVISION OF NOTICE OF PRIVACY PRACTICES:**

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised Notice at Vanguard Brain and Spine Specialists and will make paper copies of the revised Notice of Privacy Practices available upon request.

**ACKNOWLEDGMENT:**

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Vanguard Brain and Spine Specialists' Notice of Privacy Practices.

\_\_\_\_\_  
Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Representative's Relationship to Patient

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Witnessed By

\_\_\_\_\_  
Date



# VANGUARD

Brain & Spine Specialists

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NEUROSURGERY | PHYSIATRY | IMAGING

**Formerly Guilford Neurosurgical Associates**

**Our New Office Address:  
1130 N. Church Street, Suite 200  
Greensboro, NC 27401**

