THE GEORGIA NEUROSURGICAL INSTITUTE, 840 PINE STREET, SUITE 880 MACON, GA 31201 (478-743-7092)

How did you hear about our practice? □ Doctor Referred □GNI Web Site □Billboard

□Print □Online □ Patient: _____

Today's Date _____/_____/_____

Pharmacy Name, Address and Phone Number

_____

_____

Patient Last Name First Middle		**Marital Status: □ Single □Married □ Divorced □Separated □ Widowed**
Race: □Black/African American □ Hispanic □ White □Asian □ Other		**E- Mail Address:**
Mailing Address	**Social Security Number**	**Birth Date Age Sex / / □ M □ F**
City State Zip	**Primary Phone ( )**	**Cell Phone ( )**
Emergency Contact	**Phone ( ) Cell ( )**	**Relationship to Patient**
Patient's Employer:	**Occupation:**	
Referring Physician	**Primary Care Physician**	

INSURANCE INFORMATION

Primary Insurance	**Policy Number**		**Group Number**
Subscriber's Name	**Subscriber's Social Security Number**		**Birth Date / /**
Patient's Relationship to Subscriber	**□ Self □ Spouse □ Child □ Other**		
Secondary Insurance	**Policy Number**		**Group Number**
Subscriber's Name	**Subscribers Social Security Number**		**Birth Date / /**
Patient's Relationship to Subscriber	**□ Self □ Spouse □ Child □ Other**		
Person Responsible for Bill	**Birth Date / /**	**Address (if different)**	**Home Phone ( ) -**

Is this a Worker's Compensation Claim? □ Yes □ No
DOI:_____ Claim #:_____

Adjuster's Name: _____ Adjuster's Phone Number:_____

Is the injury related to an auto accident? □ Yes □ No

Date of Accident: _____ Adjuster's Name: _____

Name of Auto Ins: _____ Claim #: _____

Do You have an attorney? □ Yes □ No Name and Phone # of Attorney _____

Medications	Dosage	Frequency (How Often)	Prescribing Physician

CHIEF COMPLAINT

Onset of Pain: _____/_____/_____

Explain, in your own words, your problem today: _____
_____

Did you have to go to the emergency room? □ Yes □ No

If yes, please list name of Emergency Room and give date treated:
_____

_____

PAST MEDICATIONS USED TO TREAT MY BACK/LEG/NECK/HEAD SYMPTOMS

	Did It Help?			
□ Aspirin	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Pain Tylenol	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Motrin / Ibuprofen / Advil	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Darvon / Darvocet	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Vicodin / Hydrocodone	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Mobic / Celebrex	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Percocet / Oxycodone	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Valium	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Muscle Relaxants	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Lyrica / Neurontin	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Antidepressants	□ Yes	□ No	Begin Date: _____	End Date: _____
□ Other _____			Begin Date: _____	End Date: _____

ALLERGIES

Are you allergic to latex? □ Yes □No

Are you allergic to shellfish? □ Yes □No **What type of Shellfish?** _____

Are you allergic to any type of tape? □ Yes □ No **List:** _____

Are you allergic to any medications? □ Yes □ No **List:** _____

Are you allergic to any foods? □ Yes □ No **List:** _____

Other Allergies: _____

HOSPITALIZATIONS OR ANY TYPE OF SURGERY

Please list ALL surgeries **Date of surgery** **Complications**

_____

_____

_____

_____

□ **I have never had surgery**

PREVIOUS TREATMENTS

Please include when and where any of the following treatments were performed (only on body part you're being treated for today). IN THE PAST 6 MONTHS

Epidural Steroid Injections: □ Yes □ No **Begin Date:**_____ **End Date:**_____
Where:_____

Physical Therapy for 6 to 8 weeks: □ Yes □ No **Begin Date:**_____ **End Date:**_____
Where:_____

Home Exercises for 6 to 8 weeks: □ Yes □ No **Begin Date:**_____ **End Date:**_____

TENS Unit/ Massage Therapy: □ Yes □ No **Begin Date:**_____ **End Date:**_____

Other: _____

PLEASE LIST PHYSICIANS THAT HAVE TREATED YOU IN THE PAST

Neurosurgeon:	
Orthopedic Surgeon:	
Neurologist:	
Last Physical Exam:	
Physiatrist:	
Psychiatrist:	**Suicide Attempt □ Yes □ No**
Chiropractor:	
Rheumatologist:	
Pain Clinic:	
Other:	

FAMILY HISTORY

	HIGH BLOOD PRESSURE	DIABETES	CANCER	HEART DISEASE	BLEEDING DISORDER	LUNG DISORDER
FATHER						
MOTHER						
BROTHER(S)						
SISTER(S)						
CHILDREN						

SOCIAL HISTORY

Highest level of Education: _____

Smoking History: □ Never □ Quit □ I currently smoke ____ packs each day □ Cigars □Chewing Tobacco

Alcohol Use: □ Never □ Occasionally □ Daily □ Former Drinker

With which hand do you write? □ Left □ Right Weight _____ Height _____

PLEASE INCLUDE WHEN, WHERE AND DATE THE TEST WAS PERFORMED

(On body part you are being treated for today)

X-Ray/ CT: _____

MRI: _____

Myelogram/Dsicogram:_____

Bone Scan: _____

Electrical Nerve Testing (EMG): _____

Nerve Root or Facet Injection: _____

Please Check if You Have Ever Been Diagnosed or Treated for Any of the Following:

If female, are you pregnant □ Yes □ No

□ Anemia (Low Blood Count)
□ Bleeding Ulcers / Bleeding Disorder
□ Deep Vein Thrombosis/ Blood Clots
□ Varicose Veins
□ Hip Pain
□ Neck, Back Pain (please circle)
□ Extremity Pain Right Left Both
□ Arthritis / Gout
□ Foot / Toe Pain Right Left Both
□ Difficulty Walking

□ Headaches
□ Seizures
□ Syncope / Passing Out / Dizziness
□ Epilepsy
□ Hearing Loss
□ Difficulty Swallowing / Speaking
□ Tremors
□ Bipolar Disorder
□ Heat or Cold Intolerance

CARDIO

□Heart Attack/MI Year_____
□A-FIB (Atrial Fibrillation)
□Heart Cath Year_____ Stents_____
□Pacemaker Year_____
□Irregular Heartbeat
□Congestive Heart Failure
□Heart Murmur
□Mitral Valve Prolapse
□High Blood Pressure
□High Cholesterol
□Stroke / TIA / CVA
□ Blood Thinners

GI / UROLOGY

□ Diverticulosis / Diverticulitis
□ Crohn's Disease
□ Ulcerative Colitis
□ Renal Failure
□ Kidney Stones
□ Prostate Trouble
□ Swelling (Edema) Location _____
□ Urinary Tract Infection
□ Sexual Malfunction
□ Acid Reflux/GERD

PULMONARY

□COPD
□History of Pulmonary Embolism
□ Pneumonia
□Emphysema □ Use CPAP Machine
□Asthma
□Obstructive Sleep Apnea
□On Oxygen? _____ □ 24 hours or □ Bedtime Only

DO YOU HAVE

□ HIV / AIDS/ Venereal Disease
□ Hepatitis A B C D
□ Tuberculosis / Positive Skin test Date: _____
□ Lupus
□ Fibromyalgia
□ Chemical Dependency
□ Liver Disease
□ Graves Disease

THYROID

□Hyper □ Endocrine Disorder
□Hypo □Goiter

Diabetes: □ Type 1 □ Type 2
How Long? _____
Is it under control? □Yes □No

CANCER: Location: _____
Diagnosed Date: _____

Chemo? □Yes □No How many treatments? _____
Radiation? □Yes □No How many treatments? _____

Please check box for positive symptoms and describe or add others, if needed.

Constitutional:
- □ fever
- □ weight gain
- □ weight loss
- □ loss of appetite

Skin:
- □ lesions
- □ Rashes

Eyes:
- □ double vision
- □ blurring
- □ difficulty seeing

ENT:
- □ deafness
- □ hoarseness
- □ vertigo

Cardiovascular:
- □ palpitations
- □ irregular/rapid heartbeat
- □ chest pain

Respiratory:
- □ wheezing
- □ shortness of breath
- □ chronic cough

Digestive:
- □ abdominal pain
- □ constipation
- □ diarrhea
- □ bowel incontinence

Urinary:
- □ pain with urination
- □ hesitancy
- □ urinary incontinence

Psychiatric:
- □ anxiety
- □ sleep disturbances
- □ depression

Musculoskeletal:
- □ stiffness
- □ joint pain/deformity
- □ spine pain
- □ muscle wasting
- □ weakness
- □ pain radiating to arms/legs

Neurological:
- □ loss of balance/coordination
- □ paralysis
- □ numbness
- □ loss of sensation in arms/legs
- □ tingling
- □ loss of memory
- □ facial pain

Other Current Symptoms:

_____
_____
_____
_____

THE GEORGIA NEUROSURGICAL INSTITUTE
840 PINE STREET, SUITE 880, MACON, GA 31201 (478-743-7092)

1. **I understand I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).**

2. **I authorize my insurance carrier to release information regarding my coverage to Georgia Neurosurgical Institute, PC. I also authorize previous physicians to furnish Georgia Neurosurgical Institute, PC copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed, including for the purpose of initiating claim denial(s)/ reconsideration on my behalf. I also agree to a review of my records for purpose of the internal audits, research and quality assurance reviews within Georgia Neurosurgical Institute, PC.**

3. **My right to payment for pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Georgia Neurosurgical Institute, PC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plan. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payment to Georgia Neurosurgical Institute, PC.**

4. **I understand that my patient information arising out of my medical treatment by my physician practice (without identifying me or any other patient by my name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) governmental bodies (such as the FDA and HCFA); (c) representatives and agents of my health benefit plan; (d) persons conducting quality or peer review or patient satisfaction surveys; (e) other clinical and non-clinical parties that have a contractual relationship with Georgia Neurosurgical Institute, PC.**

5. **PERSONAL VALUABLES: I acknowledge that Georgia Neurosurgical Institute, PC shall not be liable for the loss or damages to any personal property.**

6. **CONSENT FOR PHOTOGRAPH: I, the undersigned, give Georgia Neurosurgical Institute, PC, its physicians and staff, permission to make photographs of me for placement into my clinical record.**

7. **By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s).**

THIS AGREEMENT/ CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

_____ _____

Patient Signature **Date**

_____ _____

Responsible Party Signature **Relationship to Patient** **Date**

GEORGIA NEUROSURGICAL Institute

BRAIN & SPINE SPECIALISTS

I hereby agree to let individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Georgia Neurosurgical Institute physicians and staff to disclose my personal medical information to the following individuals (family members, friends, spouse, attorney, etc.):

Name:	Relationship to patient	Phone (_____)_____
Name:	Relationship to patient	Phone (_____)_____
Name:	Relationship to patient	Phone (_____)_____
Name:	Relationship to patient	Phone (_____)_____

Condition for Disclosure (Check the Item(s) that apply):

___ The practice may disclose my personal health information to the individual(s) above only in my presence.

___ The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile, email, or regular mail.

___ Other conditions of disclosure: (Please specify)

_____

I understand that this consent may be revoked by me at any time by written notice to the practice.

Signature _____ ***Date:***_____

CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program *(Health Exchange).* This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

___ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record.

___ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record.

_____	_____	_____
Printed Name of Patient/Representative	Signature of Patient/Representative	Date

AUTHORITY OF REPRESENTATIVE

I,_____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient):_____

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse. drug abuse and alcohol abuse; HJV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to re-disclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet,

"A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Heath Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*