# Patient Information/Intake Form

Patient's Name (Last, First, MI) Sex Age Date of Birth

Address (street address/Apt# City State Zip Telephone Number

Social Security Number Status: Married Single Divorced Widowed Separated

Patient Employed By Occupation Employer's Address Employer's Phone Number

Responsible Party: Self Spouse Parent/Guardian Other: Cell Number:

In case of Emergency, whom should we contact?

**Primary Insurance Information**

Subscriber Name Relationship to Patient Birthdate Social Security Number

Address if different from patient Phone number

Employer Employer's Address Employer's Phone Number

Insurance Company Name Insurance Company Address

Subscriber Number Group Number Insurance Co. Phone Number

Your feedback is valuable to us. We are collecting reviews about your visit today. May we share your contact information with a representative outside Iredell Health System to contact you for review purposes? (Please note that only your name, email address, and phone number will be shared. No information about the services you received will be shared. Contact information will not be shared with any other agency.)

_____ Yes, I consent to be contacted. _____ No, I do not consent.

EMAIL ADRESS AND CELL NUMBER:_____

**Please read all of the following and Acknowledge by Signing**

***ACCEPTANCE OF FINANCIAL RESPONSIBILITY:*** I understand that I am responsible for all medical expenses of insurance coverage and whether or not there is an accident with another regardless person at fault. Payment is expected at the time of service unless prior arrangements have been made. I know that I am responsible for bringing my insurance card to the office.

***ASSIGNMENT OF BENEFITS***: I hereby authorize payment directly to Iredell NeuroSpine for the medical and/or surgical benefits of my insurance plan including Medicare. This payment guarantee will continue to be valid for any future visits to this practice.

***AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION:*** I understand that Iredell NeuroSpine may use my personal health information for the purposes of carrying out treatment, obtaining payment and evaluating the quality of services provided. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that other physicians involved in my care will be kept informed of my treatment. I hereby consent to the use and disclosure of my personal health information for the purposes noted in the Practice's Notice of Patient Information Practices. I understand that I have the right to revoke this authorization in writing, at any time by sending such written notice to the Practice Administrator at the address listed below.

***CONSENT FOR EVALUATION AND TREATMENT:*** I hereby authorize Iredell NeuroSpine, their physicians, employees or agents to perform a physical examination and/or medical treatment deemed necessary by the treating physician. This includes, but is not limited to any required medical examination, procedure or test ordered by the physician to be carried out by designated staff.

_____ Date:_____/_____/_____

Signature of Patient, Parent or Guardian

Address Correspondence to: Office Manager, 766 Hartness Rd, Ste C, Statesville, NC 28677

Name:_____ Date of Birth:_____/_____/_____

Cell Phone:_____ Occupation:_____

Reason for today's visit:_____

When did your symptoms first start?_____

If work related, what were you doing at the time of the accident?_____

Date of injury:_____/_____/_____ Date reported to employer:_____/_____/_____

Was this a result of a motor vehicle accident (MVA)?_____ Date:_____/_____/_____

Have you received any treatment for this problem?_____ If so, who did you see?_____

Please circle if you have had: Medications Physical Therapy Chiropractic Care Surgery

Dates of treatment:_____

Do you have any of the following? Circle all that apply. If no, select none.

| | | | | | | |
|---|---|---|---|---|---|---|
| **General** | Weight loss | Recent fever | Loss of appetite | | | |
| **Skin** | Skin ulcers | Lumps | Frequent rash | | | |
| **HEENT** | Hearing loss | Tooth pain | Changes in vision | Bleeding gums | hoarseness | Ringing in ears |
| | Frequent sore throat | | | | | |
| **Heart/Lungs** | Chest pain | Palpitations | Chronic cough | Shortness of breath | | |
| **Gastrointestinal** | Heartburn | Blood in stool | Difficulty swallowing | Nausea | Vomiting | Constipation |
| | Loss of bowel control | | | | | |
| **Genitourinary** | Hesitancy | Blood in Urine | Difficulty urinating | Painful urination | | |
| **Musculoskeletal** | Arm weakness | Neck pain | Difficulty walking | Leg weakness | Back pain | Leg pain |
| | Joint pain | Joint swelling | | | | |
| **Neurological** | Dizziness | Headaches | Falls | Numbness | Tingling | Balance problems |
| **Psychiatric** | Depression | Sleep disorder | Anxiety | Suicidal thoughts | | |
| **Endocrine** | Cold intolerance | | Heat intolerance | Excessive thirst or hunger | | |
| **Hematology** | Easy bruising | Easy bleeding | | | | |

**PAST MEDICAL HISTORY** Please circle all that apply

| | | | | |
|---|---|---|---|---|
| High blood pressure | Stomach ulcers | COPD Diabetes | Sleep apnea | Heart attack (year_____) |
| High cholesterol | Acid reflux | Sickle cell disease | Thyroid problems | Stents (year_____) |
| Osteoarthritis | Liver disease | Bleeding disorder | History of MRSA | Pacemaker |
| Rheumatoid arthritis | Kidney disease | Blood clots (year____) | HIV positive | Cancer (Location & year _____) |

Any other medical problems:_____

**ALLERGIES** (Please include your REACTION to listed allergies)

Medication Allergies:_____

Other Allergies:_____



Iredell Health System

557 BROOKDALE DRIVE
STATESVILLE, NC 28677-1828
PHONE 704-873-5661

**FAMILY HISTORY** (Please circle if your family member has any of the following. If deceased, list reason for death if known.)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mother: | High blood pressure | Diabetes | Heart disease | Cancer | COPD | Asthma | Deceased |
| Father: | High blood pressure | Diabetes | Heart disease | Cancer | COPD | Asthma | Deceased |
| Sister: | High blood pressure | Diabetes | Heart disease | Cancer | COPD | Asthma | Deceased |
| Brother: | High blood pressure | Diabetes | Heart disease | Cancer | COPD | Asthma | Deceased |

**SOCIAL HISTORY**

Are you right- or left-handed? Right Left

Do you smoke? Current every day smoker How much per day?_____

Occasional Smoker Former Smoker Quit date:_____/_____/_____

How long have you smoked?_____ Never a smoker

Do you use other Tobacco products (please list type)?_____

Do you use alcohol? Yes No Type & Amount:_____

Do you use recreational drugs? Yes No Which?_____

Do you consume caffeine? Yes No How much?_____

Do you have metal in your body? Yes No Where?_____

Are you taking or have you ever taken blood thinners? Yes No List:_____

**MEDICATIONS** Include prescription, over the counter & vitamins/supplements.

| Name of medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list previous surgeries:

_____

_____

_____

Have you ever had any problems with anesthesia? Yes No

If yes, please explain:_____

Please list your pharmacy: Local pharmacy:_____

Mail-in Pharmacy:_____



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**FINANCIAL POLICY**

Insurance coverage and payment responsibility issues can be complex and confusing. To avoid any misunderstanding, we have established the following financial policies.

**Insurance Coverage**
Our office is **required** by our contract with your insurance to collect co-payments and deductibles for services at the time they are rendered. We accept cash, personal checks, and debit/credit cards (Visa and MasterCard). Please note, even though we may accept your insurance, this may not always mean we are in-network. It is your responsibility to check with your insurance provider to make sure we are in-network. If not, you may be responsible for any unpaid balances.

**Authorization and Referrals**
If your insurance policy requires an authorization or referral from your primary care physician, it is your responsibility to ensure this has been completed.

**Self-Pay**
If you have no insurance or proof of a valid insurance card, Iredell NeuroSpine/Miller NeuroSpine requires a $200 deposit prior to treatment. Please note, the $200 is NOT a flat fee. It only covers a portion of the new patient visit charge. If you have a follow-up appointment, you will also be responsible for any charges incurred on that date of service.

**Worker Compensation**
Iredell NeuroSpine/Miller NeuroSpine will verify coverage of work-related claims prior to treatment. Make sure that you provide the office with a contact name and phone number of your employer or claim carrier. A claim number is pertinent at the time service is rendered. If you cannot provide us with this information, we will have to reschedule your appointment until information is available or we will be more than happy to file your insurance. Any claims that are disputed by your employer or not paid will convert to your responsibility. We will ask for your health insurance card to keep on file in case your claim is determined to not be employment related.

**Litigation, Liability, Auto Insurance**
Iredell NeuroSpine/Miller NeuroSpine does NOT file to third party liability insurance, nor will we wait on settlements from litigation to pay for services rendered. We will file your health insurance for services. If needed, we will provide you with an itemized statement of charges for you to present for reimbursement from the third party.

**Surgical Procedures**
We will work with you to calculate a pre-payment deposit for surgical procedures. This payment amount will consist of any remaining deductible you still owe and co-payment amount of surgery. We offer various methods of payment including cash, check, debit cards, and credit cards.

**I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility.**

_____ Date:_____/_____/_____
Signature of Responsible Party (Guarantor if patient is a minor)

_____ Date:_____/_____/_____
Witness (**Office Staff**)



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