



Austin Brain & Spine

A division of the  Seton Brain & Spine Institute

Patient Information

Date _____

Patient Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ Age _____ Social Security # _____ - _____ - _____

Sex (circle one) Male / Female Height _____ Weight _____

Phone (home) _____ (cell) _____ (work) _____

Patient Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Spouse/Parent Name _____

Relation to Patient _____ Social Security # _____ - _____ - _____

Spouse/Parent Phone (home) _____ (cell) _____ (work) _____

Spouse/Parent Employer _____ Occupation _____

Person responsible for payment, if not above _____

Who referred you to our practice? _____

Who may we contact in case of an Emergency, or rescheduling an appointment if you are unavailable?

Name _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Primary Care Physician (PCP) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Referring Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____



Austin Brain & Spine

A division of the  Seton Brain & Spine Institute

Insurance Information

Primary Carrier _____

Claims Address _____ City _____ State _____ Zip _____

Subscriber # _____ Group # _____ Phone _____

Subscriber Name _____ Relationship _____

Secondary Carrier (if applicable) _____

Claims Address _____ City _____ State _____ Zip _____

Subscriber # _____ Group # _____ Phone _____

Subscriber Name _____ Relationship _____

Date of injury _____ **Was it work-related?** _____

Testing / Surgery Information

Will you require sedation for diagnostic testing? _____

Do you have any metal in your body? _____ Worked around metal? _____

Do you have an allergy to iodine? _____

If medically necessary, would you allow the use of blood or blood products during surgery? _____



Austin Brain & Spine

A division of the  Seton Brain & Spine Institute

Medical History

History of present illness – Please briefly describe why you are here and how long you have been experiencing your current symptoms:

Review of symptoms (check all that apply):

1. General

weight loss

weight gain

fever

2. HENNA

blurry vision

double vision

nosebleeds

hoarseness

loss of smell

ringing in ears

3. Pulmonary

shortness of breath

coughing blood

4. Cardiovascular

chest pain

irregular heartbeat

ankle swelling

5. Gastrointestinal

heartburn

nausea/vomiting

rectal bleeding

incontinence

6. Genito-Urinary

incontinence

frequent urination

blood in urine

painful urination

7. Neuro

headaches

seizures

weakness

visual changes

8. Endocrine

cold intolerance

hair loss

impotence

9. Integ

acne

skin color change

pruritus

10. Women Only: Last menstrual period _____

breast discharge

801 W. 38th St, Suite #400, Austin, TX 78705 · Phone (512) 306-1323 · Fax (512) 306-1142

Matthew Hummell, MD; Craig Kemper, MD; Marcella Madera, MD

Daniel Peterson, MD; Hari Tumu, MD; Ronald Wilson, MD

www.AustinBrainandSpine.com



Austin Brain & Spine

A division of the  Seton Brain & Spine Institute

Past Medical History

<input type="checkbox"/> asthma	_____
<input type="checkbox"/> heart disease	_____
<input type="checkbox"/> lung disease	_____
<input type="checkbox"/> kidney disease	_____
<input type="checkbox"/> diabetes	_____
<input type="checkbox"/> bleeding problems	_____
<input type="checkbox"/> high blood pressure	_____
<input type="checkbox"/> AIDS/HIV	_____
<input type="checkbox"/> liver disease	_____
<input type="checkbox"/> high cholesterol	_____
<input type="checkbox"/> other (accidents, etc.)	_____

Past Surgical History

Procedure	Doctor	Date
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____

Family History

Condition	Relative
<input type="checkbox"/> heart disease	_____
<input type="checkbox"/> cancer (location and type)	_____
<input type="checkbox"/> diabetes	_____
<input type="checkbox"/> high blood pressure	_____
<input type="checkbox"/> tuberculosis	_____
<input type="checkbox"/> migraines	_____
<input type="checkbox"/> stroke	_____



Austin Brain & Spine

A division of the  Seton Brain & Spine Institute

Current Medications

Medicine	Dosage	Frequency
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____
8 _____	_____	_____

Allergies

- 1 _____
 - 2 _____
 - 3 _____
- None known _____

Social History

Occupation _____

Tobacco ____ none

____ previously ____ # of years ____ packs per day ____/____/____ date quit

____ currently ____ # of years ____ packs per day

Alcohol ____ drinks per week

Illicit Drug Use _____

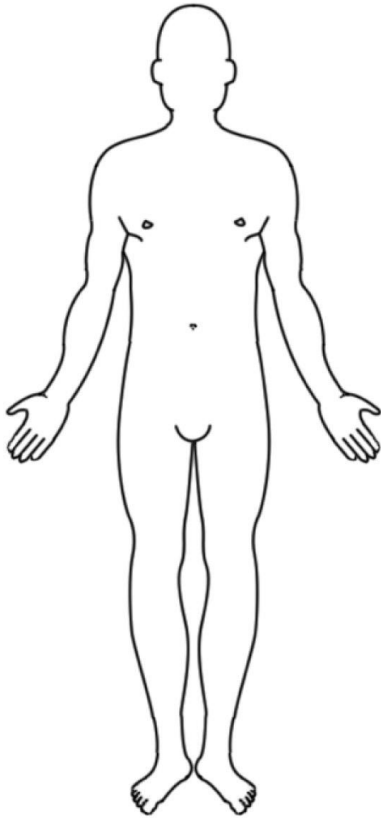


Austin Brain & Spine

A division of the  Seton Brain & Spine Institute

Name _____ Date _____

Mark these drawings according to where you hurt (if the back of your neck, mark the drawing on the back of the neck, etc). If you feel any of the following symptoms, please indicate where you feel them by placing the appropriate marks on the diagrams. Include all affected areas.



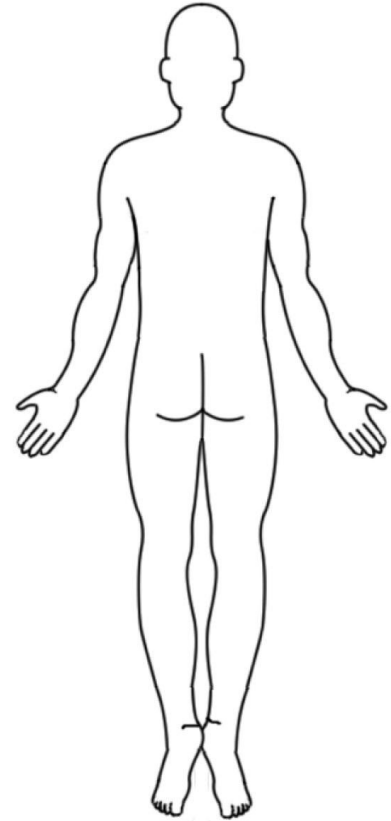
Numbness
11111

Pins and Needles
00000

Burning
#####

Stabbing
/////

Ache



1. How bad is your pain now?
2. Please mark with an X on the body form where the pain is worst now.
3. Please circle the appropriate number below representing how bad your pain is now.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain



Austin Brain & Spine

A division of the  Seton Brain & Spine Institute

Medical Records / X-ray Release of Authorization (Doctor/Hospital)

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity named below.

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Limitations of the information you may release subject to this release form are:

I authorize the payment of medical benefits to be made directly to Austin Brain & Spine for services rendered.

I understand that any forms related to medical or disability leave will not be kept with my medical records maintained by Austin Brain & Spine. It will be my responsibility to follow up and maintain all medical or disability leave forms.

Patient Name (please print) _____

Social Security # _____ Date of Birth _____

Patient Signature (or parent, guardian, or legal representative) Date

Witness Date



Austin Brain & Spine

A division of the  **Seton** Brain & Spine Institute

Medical Forms

We will complete the first form for \$25.00. There will be an additional \$25.00 charge per form thereafter. This charge is payable in advance when the forms are submitted to us for completion.

Seven (7) working days are necessary to complete paperwork.

Medical forms CANNOT be completed on the day when you are seen by your doctor. DO NOT bring forms to surgery as they can easily be misplaced. All forms must be delivered to our office.

Medical Records

Copies of records or request for transfer of records to other physicians must be in writing. Please contact our Medical Records Department for all record requests.

Patient Signature (or parent, guardian, or legal representative)

Date

801 W. 38th St, Suite #400, Austin, TX 78705 · Phone (512) 306-1323 · Fax (512) 306-1142

Matthew Hummell, MD; Craig Kemper, MD; Marcella Madera, MD

Daniel Peterson, MD; Hari Tumu, MD; Ronald Wilson, MD

www.AustinBrainandSpine.com



Austin Brain & Spine

A division of the  Seton Brain & Spine Institute

Patient Responsibility Policy

Patients are responsible for knowing which facility is participating with their insurance carrier in regard to hospitals, outpatient testing, labs, etc.

Purpose: To ensure all patient responsibility balances are collected in a timely manner.

Policy: To collect all patient responsibility balances in the following manner.

Rates: We must comply with our contract negotiations; consequently, our rates are fixed.

Copays: All copays are collected prior to the visit. If you are not prepared to make your copay, your visit will have to be rescheduled.

Insurance: If your insurance does not pay 100%, you are responsible for paying any balances before each visit and/or surgery.

Self Pay: All visits to the doctor will require payment at the time services are rendered. No surgery will be scheduled until financial arrangements have been made with the bookkeeper.

Balances: All balances after insurance has been processed will be due in full after 30 days.

Collections: Any patient that has been placed in collections must pay prior balance owed to the practice, as well as any collection agency fees, in cash before the practice will see you again.

Payments: If a check is not honored by your banking institution then the balance of your account, in addition to a \$25.00 return check fee, will be due in full upon receipt of notification.

Payment Plan: The payment schedule is as follows:

<u>Balance</u>	<u>Monthly Payment</u>
\$ 0 to \$ 99.00	\$ 25.00
\$ 100.00 to \$ 499.00	\$ 50.00
\$ 500.00 to \$ 999.00	\$ 100.00
\$ 1000.00 to \$ 2500.00	\$ 200.00
\$ 2500.00 to \$ 5000.00	\$ 300.00
Over \$ 5000.00	\$ 500.00

Patient Signature (or parent, guardian, or legal representative)

Date

801 W. 38th St, Suite #400, Austin, TX 78705 · Phone (512) 306-1323 · Fax (512) 306-1142
Matthew Hummell, MD; Craig Kemper, MD; Marcella Madera, MD
Daniel Peterson, MD; Hari Tumu, MD; Ronald Wilson, MD
www.AustinBrainandSpine.com