

PATIENT INFORMATION - PLEASE PRINT

PATIENT NAME: _____ SOCIAL SECURITY #: _____

LOCAL ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: _____ CELL: _____

EMAIL: _____ COMMUNICATION PREFERENCE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

HAND DOMINANCE: *LEFT OR RIGHT* RACE: _____ ETHNICITY: _____

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

PERSON RESPONSIBLE FOR BILL: _____

RELATIONSHIP: _____ D/O/B: _____ OWN OR RENT: _____

NORTHERN OR ALTERNATE ADDRESS: _____

PRIMARY DOCTOR: _____ REFERRING DOCTOR: _____

PHARMACY: _____ LOCATION: _____

CITY _____ PHONE: _____ *CROSS STREET*

DO YOU HAVE AN ADVANCE DIRECTIVE?

YES NO NAME: _____

ARE WE SEEING YOU BECAUSE OF THE FOLLOWING?

AUTO ACCIDENT? _____ DATE: _____ WHERE OCCURRED: _____
WRITE YES OR NO

WORKERS COMPENSATION: _____ DATE: _____ REPORTED TO EMPLOYER: _____
WRITE YES OR NO

NAME OF YOUR ATTORNEY: _____ PHONE: _____

EMPLOYMENT INFORMATION

PATIENT EMPLOYER: _____ YOUR POSITION: _____

ADDRESS: _____ WORK PHONE: _____

PLEASE READ

PLEASE GIVE OUR RECEPTIONIST YOUR INSURANCE CARDS SO THAT WE MAY PHOTOCOPY THEM. WE HAVE REQUESTED YOUR INSURANCE INFORMATION FOR OUR RECORDS ONLY. PAYMENT IS EXPECTED AT THE TIME OF SERVICE, UNLESS WE PARTICIPATE WITH YOUR INSURANCE, OR YOU HAVE *PREVIOUSLY* SET UP A PAYMENT PLAN WITH OUR OFFICE. **CO-PAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.** DR. CASSIDY AND DR. GUERIN DO PARTICIPATE WITH MEDICARE. PLEASE DO NOT HESITATE TO DISCUSS ANY QUESTIONS REGARDING YOUR INSURANCE OR PAYMENT WITH US.

PAST MEDICAL HISTORY:

Do you have or have you EVER had any of the following:

<i>Self</i>	
	Acid Reflux
	Anesthesia problem
	Angina
	Any breathing problem
	ANY Heart problem
	Arthritis
	Asthma
	Bleeding problem
	Bladder
	Blood clots
	Blood pressure
	Blood Transfusion
	Bowel
	Cancer
	Chest pain
	Claustrophobia
	COPD
	Diabetes
	Emphysema
	Hearing Loss
	Heart Fibrillation
	Hepatitis
	HIV or AIDS
	Kidney problems
	Pacemaker
	Psychiatry evaluation
	Recent fever
	Seizures
	Skin rash/Blisters
	Sleep Apnea
	Stroke
	Tumor
	Ulcers
	Visual problems
	Weight Change
	**Other Medical Conditions:

FAMILY MEDICAL HISTORY: _____

Neurosurgical Associates, Cassidy & Guerin, M.D., P.A.

Name: _____ Date of Visit: _____

Date of Birth: _____ Gender: _____ Age: _____ Dr. You are seeing: _____

Family Physician: _____ Referring Physician: _____

TO BE COMPLETED BY OFFICE

Height: _____ Weight: _____ B/P: _____ Pulse: _____

MEDICAL HISTORY

WHAT MEDICAL PROBLEM BRINGS YOU HERE TODAY? _____

ALLERGIES

Yes: _____ No: _____

Latex Allergy: _____

List all allergies below:

ALL CURRENT MEDICATIONS

List drug names, dose, number of times per day

Do you take Aspirin? _____ Do you drink alcohol? _____ Smoker: Yes No Amt: _____

RECENT FLU / PNEUMONIA VACCINE: YES or NO DATE: _____

OPERATIONS (include yr)

MEDICAL ILLNESSES or HOSPITAL ADMISSIONS(incl yr)

NEUROSURGICAL ASSOCIATES, CASSIDY & GUERIN, M.D., P.A.
AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT:

Name of Patient:

Patients Date of Birth:

Street Address:

City, State, Zip

I AUTHORIZE:

**RELEASE OF PROTECTED HEALTH
INFORMATION FROM:**

Name:

**Neurosurgical Associate Dr Cassidy & Dr Guerin
842 Sunset Lake Blvd Venice Fl 342923**

Street Address:

City, State, Zip Code

INFORMATION TO BE RELEASED:

I hereby authorize you to release all of my medical records for any treatment and laboratory/diagnostic test performed except for information pertaining to:

- Testing or treatment of HIV/AIDS
 Treatment of alcohol or substance abuse
 Records from other facilities/providers
 Communications between patient and psychotherapist for mental health treatment

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Please check one)

- Further Medical Care
 Insurance/Eligibility
 Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization and written notification is necessary to cancel this authorization. I understand I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Neurosurgical Assoc. Cassidy and Guerin, M.D., P.A will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, Neurosurgical Assoc. will not refuse to continue treatment. By signing this form, I do expressly and voluntarily consent to disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by federal privacy standards, the health information disclosure as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

SIGNATURE OF PATIENT/LEGAL REP:

TODAYS DATE:

If signed by other than patient, state relationship and authority to do so

EXPIRATION DATE: This authorization is good until the following date(s): 1 year from date of signature.