Workers Compensation
Patient Registration Form

Treating Doctor: _____ PCP: _____

Patient Name: _____ Date of Birth: _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: (Primary)_____ (Cell)_____ (Work)_____

Social Security #: _____ Email:_____

Gender: ☐ M ☐ F Driver's License #: _____ State: _____

Marital Status: ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorced

Employment Status: ☐ Full Time ☐ Part Time Name of Employer: _____

Student Status: ☐ Full Time ☐ Part Time School: _____

Spouse Name: _____ DOB: _____

Race: ☐ American Indian or Alaskan Native ☐ White ☐ Other: _____
☐ African-American ☐ Hispanic
☐ Asian ☐ Native Hawaiian

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic Language Spoken: _____

Driver's License #: _____ State: _____

Emergency Contact Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Name of Preferred Local Pharmacy: _____ Phone: _____

Address: _____

Mail Order Pharmacy: _____

Date of Injury: _____ Claim #: _____ TWCC#: _____

Employer, if different from above: _____ Phone: _____

Address: _____

Workers Compensation Carrier: _____ Phone: _____

Address: _____

Adjuster: _____ Phone: _____

TBSI OFFICE POLICIES

Welcome to TBSI Neurosurgery, part of the CHI St. Joseph Health Medical Neighborhood. Our practice is committed to providing comprehensive, patient-centered neurosurgical care to you and your family.

Care Team Responsibilities: We pride ourselves on providing you with team-based care in which each member of your care team fully utilizes their specific skills and abilities. Your care team may be comprised of physicians, physician assistants and office associates. While all are involved in your care in various ways, your neurosurgeon is the *leader* of your care team and is ultimately responsible for your treatment.

Communication: As a member of the CHI St. Joseph medical neighborhood, we work to coordinate your care across multiple settings, including primary care, other specialties and emergency medicine. Below are the communication processes you can expect from us:

- Your referring provider/primary care provider will be notified when your appointments have been scheduled and may be sent notes from your visit with us after your appointment.
- Many of your procedures, tests and prescribed medications are accessible by your care team in your electronic medical record.
- When you contact us via telephone or the web portal, we will respond to your questions as soon as possible. If your provider is not in the office, you will be notified of an expected response time given the provider's availability.
- We will release information ONLY to you, or to the individual you designated on the Medical Release of Information form.

These efforts are part of our mission to eliminate duplicate paperwork, unnecessary tests, and most importantly, provide the care you need, when you need it, and in a manner which you can understand.

Our Expectations of Our Patients: In order to allow us to provide you with the best possible care, it is important that you share your current contact information, your physical and mental health history, your medication lists, allergies as well as any social factors (living situation, relationship status, etc.) which may affect your physical, mental or emotional health. Please also provide the names and contact information of other providers you may be seeing in addition to your preferred pharmacy. This way, we can understand your health from a whole-person perspective. In the following sections you will find more information about our expectations from you as our patient.

NEUROSURGERY BUSINESS HOURS
Monday – Friday from 8:00 a.m. – 5:00 p.m.
Closed 12:00 - 1:00 p.m. for lunch

DISCLAIMER: Scheduled surgeries may cause clinic schedules to run behind, resulting longer wait times and/or cancelled appointments. We will do our best to keep you updated to any potential schedule changes as we become aware of them. Thank you for your patience.

After Hours Care: You may call our office (979-776-8896) and will have the option to either leave a voicemail by dialing 0 once or be transferred to speak to our answering service by dialing 0 again. Should the nature of your call require a clinical assessment, the neurosurgery call team will be notified in order to render appropriate care. Please be advised, all emergency care will be rendered through the nearest emergency room. If your issue is non-emergent, you may leave a message and our staff will contact you the next business day.

Urgent Care: if you are experiencing any of the following symptoms, REPORT TO THE NEAREST EMERGENCY ROOM IMMEDIATELY.

- Chest pain, especially in men over 35 and women over 45.
- Shortness of breath
- Vomiting blood
- Stroke
- Fainting spells, especially in men over 35 and women over 45.
- Throat swelling from allergic reaction
- Unable to urinate
- CSF leak with severe headache
- Deep Vein Thrombosis
- Low or high blood pressure
- Temperature over 101.5

Insurance and Payment

- We accept most forms of commercial and private insurance, as well as Medicare and Medicaid. However, it is a good idea to contact your insurance to ensure our providers are contracted with your specific plan to prevent any inconvenience or financial burden.
- If your insurance required you to have an authorization or referral from your primary care physician, our office must have received that prior to your office visit or we will be unable to see you that day.
- Uninsured patients are required to provide payment at the time of service.

Arriving for Your Appointment

- **Please remember to bring your current insurance card, photo ID, any CDs that have imaging (x-rays, MRI, CT scans) and a current medication list to your appointment.** If you are **late** arriving for your appointment or are caused to be late by not completing your paperwork prior to your appointment time, **you may be rescheduled** to the next available appointment date and time.
- **Location of Appointment:** We have multiple locations, so please confirm the location of your appointment and plan for any travel related delays that may impact your arrival time.
    - For our Bryan location, please be sure to park in the patient parking, marked with blue lines. As we are located on the Texas A&M Health Science Center Campus, we are committed to keeping convenient parking available for our patients and therefore, have these spaces actively monitored to restrict usage by students. Patient parking is conveniently located in the first two rows in front of our building. Parking in an alternate location could result in a parking citation.
- **New patients**: Please arrive ***30 minutes early*** to your appointment to fill out new patient paperwork. If your paperwork is not completed **PRIOR** to your appointment time, you may be asked to reschedule your appointment out of respect for the other patients. Unless instructed differently, new patients will see the surgeon's Physician Assistant (PA). The PA participates in every aspect of your care, including the surgery if necessary, and will be your primary point of contact for clinical questions or concerns.
- **Established patients**: For your convenience, your appointment with your neurosurgical care team may/may not follow a corresponding appointment for imaging. Please be aware of your arrival time for each office as appropriate. TBSI Imaging is located on the first floor.
- **Cancellations/Reminders**: Please call at least 24 hours before your appointment if you need to cancel. TBSI does not maintain an active cancellation list. TBSI does not routinely make reminder calls for our patient's scheduled appointment times. Please call the office to confirm your appointment if you have any questions.
- **Treatment of Minors:** Patients under the age of 18 must be accompanied by a parent/guardian or have written permission for treatment from a parent/guardian if accompanied by another adult for *every visit***.**
- **Dismissal from the Practice:** If you are "dismissed" from the practice, you can no longer schedule appointments, get medication refills, or consider any other doctors within St. Joseph Neurosurgery to be your doctor. Should you be dismissed, we will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. We will forward a copy of your medical records to your new doctor after you inform us and sign a release form.

Acknowledgement of Notice of Privacy Practices

Patient Initials_____

I acknowledge that I have been provided a copy of the Notice of Privacy Practices of CHI St. Joseph Health, Bryan, Texas.

Authorization to Inspect and Release Protected Health Information

Patient Initials_____

I authorize TBSI to release or acquire any medical information and/or medical records necessary to provide additional care such as evaluation, treatment and referrals.

For any other needs, TBSI will release information ONLY to you, or to the individual you designated on the Medical Release of Information form. This form is available on our website at www.txbsi.com or at the front registration desk in our Bryan clinic.

Name: _____ Relationship: _____ Restriction: _____ Yes _____ No

Name: _____ Relationship: _____ Restriction: _____ Yes _____ No

Please list restrictions: _____

Prescription and Medication Management

- **Prescriptions and Refills:** For refill requests, please *contact your pharmacy* at least 3 business days in advance of need. *DO NOT* wait until you have run out of medication. We do not fill any prescription refills after 5:00 pm, on weekends or during holidays.
- **Narcotic Prescriptions:** We ***DO NOT*** prescribe Schedule II medications (Hydrocodone or Norco, Vicodin, Vicoprofen, Lortab, Zydone) in the clinic.

Please sign and date that you have read and understand our office policies.
Thank you.

_____ _____
Printed Name of Patient or Personal Representative Relationship

_____ _____
Signature of Patient or Personal Representative Date

Medical History Form

THE TEXAS BRAIN AND SPINE INSTITUTE

CHI St. Joseph Health — Imagine better health.℠

Name: _____ **Date of Birth:** _____

Medical History: **(Please check if you have or had any of the following)**

□ Abuse (physical/mental/sexual/verbal, etc.)	□ Cholesterol (high)	□ Intestinal Disease
□ Abnormal Pap	□ Chronic pain	□ Kidney or Bladder Problems
□ Alcoholism/Drug use	□ Depression/mental disorder	□ Lung Disease
□ Anemia	□ Diabetes	□ Osteoporosis
□ Anxiety/nerves	□ Epilepsy/Seizures	□ Serious Accident/Injury
□ Arthritis	□ Genetic Diseases	□ Sexual Disease/VD
□ Asthma	□ Glaucoma/Cataract	□ Stroke
□ Allergies	□ Gout	□ Thyroid Disease
□ Bleeding disease	□ Headaches/Migraine	□ Tuberculosis
□ Blood transfusion	□ Heart Disease	□ Ulcers/Stomach Disease
□ Blood clots	□ Hepatitis (any)	
□ Cancer/Tumor	□ High blood pressure	

Surgical History & Date / Age If Known: _____No Surgeries

_____

_____

Do you have an advanced directive on file? Yes No

Hospitalizations: _____No Past Hospitalizations

Date/Age: _____ Reason:_____

Date/Age: _____ Reason:_____

Family History: **History Of:**

Father:	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Mother:	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown

Social History:

Tobacco Use: Yes No ☐ Former ☐ Never Drug Use: Yes No Alcohol Use: Yes No

Sexually Active: Yes No Ever had a Sexually Transmitted Disease? Yes No

Social Functioning (Wellness exams only)

During the past 4 weeks, was someone available if you needed and wanted help? For example, if you felt very nervous, lonely, or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself. □ Yes, as much as I wanted □ Yes, quite a bit □ Yes, some □ Yes, a little □ No, not at all □ I choose not to answer

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Check all that apply) □ Yes, it has kept me from medical appointments or getting my medications. □ Yes, it has kept me from non-medical appointments, meetings, work, or getting things I need. □ No. □ I choose not to answer.

Medications Currently Taking (List) Name / Dosage / How Often:

_____

_____

_____

Allergies: to medications, food, or latex (List): _____

FEMALES ONLY: Is it possible that you may be pregnant? YES NO Date of Last Menstrual Cycle: _____

Immunizations Up-To-Date? ___Current to my knowledge ___Not up-to-date ___Unknown (will discuss w/provider)

Injured at Work: YES NO Date/Time of Injury: _____

Today's Date: _____

Name:_____ Date:_____

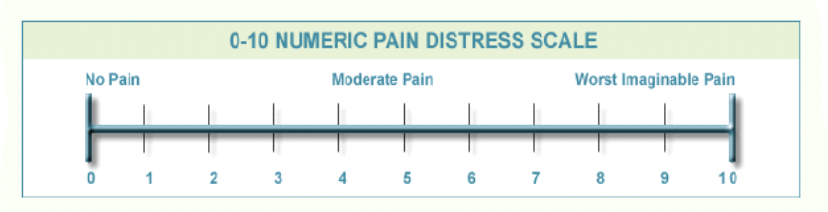
TBSI – Neurosurgery

Overall Health Status:

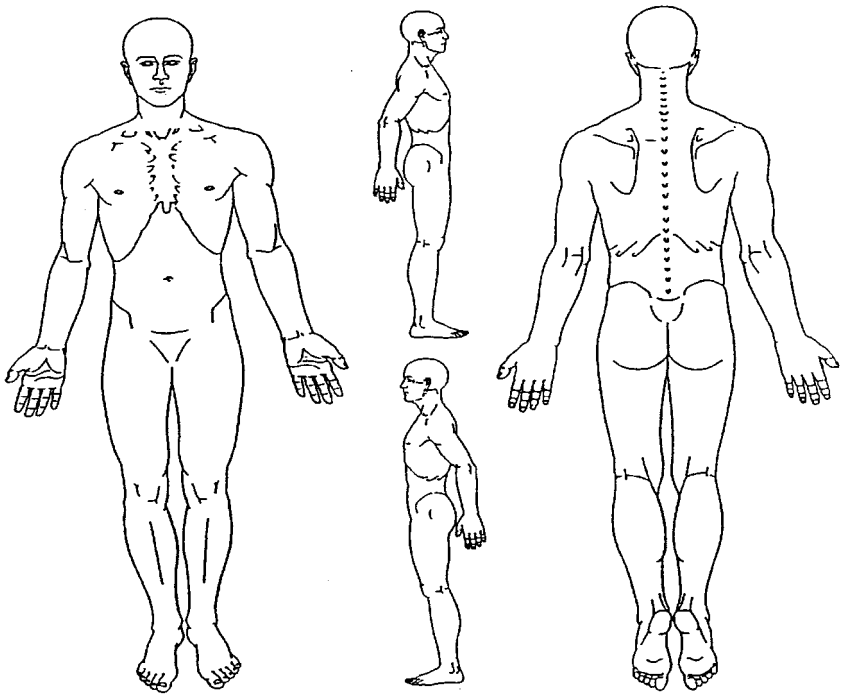
I feel my overall state of health is: ❑ Good ❑ Fair ❑ Poor

Height: _____ Weight: _____ ❑ I am right-handed ❑ I am left-handed

Pain Scale: Using the scale below, what number would you rate your ***current*** pain? _____



USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN		
A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER



1. My pain is in my: _____
2. Select one of the following:
   - ❑ My problem is chronic. It began at age: _____
   - ❑ My pain began (date and year): _____
3. Is this related to a recent injury? ❑ Yes ❑ No ❑ Possibly
   Is the injury work related? ❑ Yes ❑ No Date of injury? _____
   Date stopped work? _____
4. Please explain how it happened: _____

Name:_____ Date:_____

I also have the following problems:

- ❑ My pain awakens me from sleep
- ❑ My pain is worse at night
- ❑ I have numbness/tingling in my arms
- ❑ I have numbness/tingling in my hands
- ❑ I drop items after I pick them up
- ❑ I am off-balance when I walk
- ❑ I stumble/fall frequently or run into walls
- ❑ My arms/legs are weak because they hurt
- ❑ My legs feel weak or hurt when I walk too far:
  - ❑ This is relieved by sitting
  - ❑ This is relieved by stopping and standing
- ❑ I can walk:
  - ❑ Less than a block
  - ❑ 1-2 blocks
  - ❑ More than 3 blocks
- ❑ I awaken at night with my hands asleep
- ❑ My hands go to sleep while:
  - ❑ Driving
  - ❑ Using a computer mouse
  - ❑ Using a telephone or blow dryer
- ❑ I have weakness in my:
  - ❑ Right leg ❑ Left leg
- ❑ I have numbness/tingling in my:
  - ❑ Right leg ❑ Left leg
  - ❑ Right foot ❑ Left foot
- ❑ I have trouble with my bladder control
  - ❑ Can't empty my bladder
  - ❑ Loss of control (accidents)
- ❑ I have trouble with my bowels
  - ❑ Constipation
  - ❑ Loss of control (accidents)

Previous Treatment and Medication <u>for This Condition</u>: ❑ None

I have been prescribed for this condition:	With how much relief? None	A Little	A Lot
❑ Medications:			
❑ Anti-inflammatories: _____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
❑ Muscle relaxers: _____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
❑ Pain medication: _____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
❑ Steroid Dose Pack/Medrol/Prednisone: _____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
❑ Physical Therapy	❑	❑	❑
❑ Traction	❑	❑	❑
❑ Exercises	❑	❑	❑
❑ Spinal Injections	❑	❑	❑
❑ Manipulation: Chiropractor's Name: _____	❑	❑	❑
❑ Heat ❑ Cold	❑	❑	❑

Name:_____ Date:_____

- I have seen other doctors for my condition: ❑ Yes ❑ No

  If Yes, on what date?_____By whom? _____Where?_____

- I have had surgery before for this same type of problem. How long ago?_____

  What type of surgery?_____Physician who performed surgery?_____

- I have had the following tests: ❑ Plain X-Rays ❑ CAT Scan ❑ MRI ❑ Myelogram ❑ Discogram ❑ EMG

The following actions make me feel:

	Better	Worse		Better	Worse
Bed rest	❑	❑	Standing	❑	❑
Massage	❑	❑	Sitting	❑	❑
Stretching/Popping	❑	❑	Walking	❑	❑
Bending Backwards/Forwards	❑	❑	Heat	❑	❑
Bending to the left	❑	❑	Ice	❑	❑
Bending to the right	❑	❑	Sneezing/Coughing	❑	❑
Straining to go to the bathroom	❑	❑	Changing Positions	❑	❑

Work Essentials:

My job requirements are:

❑ I am not currently employed

❑ Heavy Lifting – over 60 lbs with frequent bending and stooping
❑ Medium Lifting – between 30-50 lbs
❑ Light Lifting – 10-20 lbs

❑ Sedentary – mostly sitting with very little lifting
❑ My job is highly stressful & it makes me tense