

**VALLEY NEURO/MICRONEUROSURGERY, S.C.**  
**K.S. PAUL, M.D.**

**PATIENT INFORMATION FORM**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Last

First

Middle Initial

Former Names: \_\_\_\_\_ (if applicable) Sex: M F

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City

State

Zip code

Phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Home

Work

Cell

Employer: \_\_\_\_\_

Name

Address

City

State

Zip code

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse (if minor: Parent/Guardian): \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City

State

Zip Code

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City

State

Zip Code

**Insurance Company**

Name: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

**Secondary Insurance Company**

Name: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Are you currently working? \_\_\_\_\_ Date last worked: \_\_\_\_\_  
Is this a work-related injury? \_\_\_\_\_ Date of Injury? \_\_\_\_\_  
File with Workman's Compensation first? \_\_\_\_\_ YES \_\_\_\_\_ NO

**Workman's Compensation**

W/C Insurance: \_\_\_\_\_ Claim #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Contact Name: \_\_\_\_\_

City State Zip Code

Employer: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip Code

Is this related to an auto accident? \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Is this a personal injury? \_\_\_\_\_ Date of Accident: \_\_\_\_\_

File with Auto/Personal Injury first? \_\_\_\_\_ YES \_\_\_\_\_ NO

**Accident/Personal Injury Insurance**

\*\*Have you filed a claim with your auto accident/personal injury insurance? \*\* \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip Code

Claim or Policy #: \_\_\_\_\_ Insured Party's Name: \_\_\_\_\_

**Attorney**

Is there a lawsuit pending? \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip Code

\*I hereby authorize the release of my medical information to the insurance carrier, employer, referring and/or family physician, necessary to process my claim and/or provide medical care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*I hereby authorize direct payment to Valley Neuro/Microneurosurgery, S.C. (K.S. Paul, M.D.) of all insurance benefits, all Medicare benefits, and all Medigap insurance benefits (as applicable) otherwise payable to me. I understand that I am financially responsible for charge(s) which are not paid and/or not covered by my insurance plan(s). This authorization is in effect until I choose to revoke it and it can be revoked at any time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# MEDICAL HISTORY

## Past Medical History *(Please check all that apply)*

High Blood Pressure	Asthma	Blood Clots
Diabetes	Tuberculosis	Depression
Cancer	Emphysema	Anxiety Disorder
Seizures	Angina	Bipolar disorder
Rheumatoid Arthritis	Heart Attack	Other Mental Illness
Gout	Irregular Heart Beat	Addiction to Alcohol
Thyroid Disease	Abnormal Heart Valve	Addiction to Other Drugs
Osteoporosis	Aortic Aneurysm	HIV / AIDS
Glaucoma	Poor Circulation	Hepatitis
Migraine Headaches	Ulcers in Stomach or Intestines	Broken Bones
Loss of Consciousness	Kidney Problems	Prolonged Prednisone Use
Stroke or TIA	Liver Problems	Sleep Apnea
Severe Head Injury	Bowel Problems	Major Trauma (accidents, falls)
Brain Aneurysm	Easy Bleeding	Other: _____

## Past Surgical and/or Hospitalization History

*(Please check the operations you have had/indicate hospitalization and for what reason)*

Tonsillectomy	Appendectomy	Gallbladder
Hysterectomy	Neck Operation	Heart Surgery
Bypass in the legs	Back Operation	Brain Surgery
Bowel Surgery	Gastric Bypass	Other: _____
Carotid Endarterectomy	Tubal Ligation	Other: _____
Abdominal Aneurysm	Cesarean Section	Other: _____

# SYSTEMS REVIEW

Are you currently (or in the last 6 months) having any of the following symptoms?

## CONSTITUTIONAL

- \_\_\_ Weight Change
- \_\_\_ Sleep pattern change
- \_\_\_ Appetite change
- \_\_\_ Fevers
- \_\_\_ Chills
- \_\_\_ Fatigue

## CARDIOVASCULAR

- \_\_\_ Chest pain
- \_\_\_ Palpitations
- \_\_\_ Swollen Ankles
- \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Other: \_\_\_\_\_

## PULMONARY

- \_\_\_ Shortness of breath
- \_\_\_ Cough
- \_\_\_ Wheezing
- \_\_\_ Heavy Snoring
- \_\_\_ Other: \_\_\_\_\_

## GASTROINTESTINAL

- \_\_\_ Heartburn
- \_\_\_ Constipation
- \_\_\_ Diarrhea
- \_\_\_ Change in bowel habits
- \_\_\_ Loss of bowel control
- \_\_\_ Trouble swallowing
- \_\_\_ Other: \_\_\_\_\_

## GENITO-URINARY

- \_\_\_ Painful urination
- \_\_\_ Frequent urination
- \_\_\_ Incontinence
- \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Other: \_\_\_\_\_

## MUSCULO/SKELETAL

- \_\_\_ Joint pain/swelling
- \_\_\_ Muscle pain/cramps
- \_\_\_ Low back pain
- \_\_\_ Neck pain
- \_\_\_ Leg pain
- \_\_\_ Arm pain

## PSYCHIATRIC

- \_\_\_ Depression
- \_\_\_ Anxiety
- \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Other: \_\_\_\_\_

## IMMUNOLOGICAL

- \_\_\_ HIV / AIDS
- \_\_\_ Blood Cancers
- \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Other: \_\_\_\_\_

## ENDOCRINOLOGY

- \_\_\_ Thyroid disease
- \_\_\_ High blood sugar
- \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Other: \_\_\_\_\_

## INTEGUMENTARY

- \_\_\_ Rashes
- \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Other: \_\_\_\_\_

## NEUROLOGICAL

- \_\_\_ Loss of balance
- \_\_\_ Headache
- \_\_\_ Weakness
- \_\_\_ Vision change
- \_\_\_ Hearing problems
- \_\_\_ Dizziness/fainting
- \_\_\_ Clumsiness
- \_\_\_ Speech problems
- \_\_\_ Numbness/tingling
  - \_\_\_ Arms \_\_\_ Hands
  - \_\_\_ Legs \_\_\_ Feet

## HEMATOLOGIC

- \_\_\_ Bleeding disorder
- \_\_\_ Easy bleeding
- \_\_\_ Easy bruising
- \_\_\_ Other: \_\_\_\_\_



**\*\*Most health insurance companies require that you receive conservative treatment before they will authorize additional testing and/or surgery. It is important that you complete this form. \*\***

CONSERVATIVE TREATMENT  
(IN THE LAST 6 MONTHS)

**Pain Relief Effect:** No Relief / Some Relief / Temporary Relief / Full Relief

ANTI-INFLAMMATORY  
MEDICATIONS

Medication Name	Date Started/Stopped	Pain Relief Effect

PAIN MEDICATIONS

Medication Name	Date Started/Stopped	Pain Relief Effect

DAILY EXERCISE

Type of Exercise	Duration	Pain Relief Effect

ACTIVITY / LIFESTYLE  
MODIFICATION

Modification Type	Date Started	Pain Relief Effect

WEIGHT REDUCTION

Reduction Type (diet, exercise, surgical procedure)	Date Started	Pain Relief Effect

SUPERVISED  
PHYSICAL THERAPY

Where was PT done?	Date Started/Stopped	Pain Relief Effect

COGNITIVE /  
BEHAVIORAL /  
ADDICTION ISSUES

Identified Issue	Treatment Received

CHIROPRACTIC CARE

Where was chiropractic care done?	Date Started/Stopped	Pain Relief Effect

OTHER  
(TENs Unit,  
Acupuncture,  
Hypnosis, Injections,  
etc.)

Type of Treatment	Date Started/Stopped	Pain Relief Effect







VALLEY NEURO/MICRONEUROSURGERY, S.C.  
K.S. PAUL M.D.

MEDICAL RECORDS

**Important notice regarding your medical records:** Your medical records with Dr. Paul, Valley Neuro/Microneurosurgery, S.C. are maintained for **10 (ten) years** after you are discharged from our care, at which time they are destroyed. You may obtain a copy of your medical records upon discharge or any time within the 10 (ten) years after discharge.

**ACCESS TO MY MEDICAL RECORDS:**

I have received information regarding setting up my Patient Fusion account and:

\_\_\_\_\_ I am choosing to opt-out from having direct access to my medical records via email

\_\_\_\_\_ I would like to have direct access to my medical records via email.

My email address is: \_\_\_\_\_

\_\_\_\_\_ I would like to receive appointment reminders via email.

\_\_\_\_\_ I would like to receive text message reminders via my cell phone.

**RELEASE OF INFORMATION**

\*By initialing here, \_\_\_\_\_, I authorize you to leave a voice mail message regarding appointment reminders or a need to return a phone call to your office.

\*By initialing here, \_\_\_\_\_, I authorize you to leave a message with anyone answering my home phone regarding appointment reminders or a need to return a phone call to your office.

\*By initialing here, \_\_\_\_\_, I authorize you to leave a message at my work that I need to return a phone call to your office.

\*I authorize you to discuss my medical records with (family member, friend, neighbor, etc.):

\_\_\_\_\_ Relation: \_\_\_\_\_

\_\_\_\_\_ Relation: \_\_\_\_\_

\_\_\_\_\_ Relation: \_\_\_\_\_

This authorization includes my medical condition, treatment, appointments, and billing information. I understand that this authorization will remain in effect unless revoked by me in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**VACCINATION STATUS** (Month and year vaccination was receive)

Pneumovax \_\_\_\_\_ Influenza \_\_\_\_\_ Tetanus \_\_\_\_\_

**CODE STATUS**

If a major medical event were to occur, would you want:

\_\_\_\_\_ Full Code (Which means you would want all medical means used)

\_\_\_\_\_ No Code (Do Not Resuscitate)

\_\_\_\_\_ I have an Advance Directive for Health Care (Living will or power of attorney for health care)

\_\_\_\_\_ I do not have an Advance Directive for Health Care and would like more information about it.

Information provided to patient \_\_\_\_\_

**Valley Neuro/Microneurosurgery, S.C.**  
**PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT**

*We would like to thank you for choosing us as your healthcare provider. We are committed to providing you the best service possible. As one of our patients, we would like to keep you informed of our office and financial policies. Please feel free to call us if you have any questions regarding these policies.*

**Insurance Claims:** As a courtesy to you, we file insurance claims with your insurance carrier for you. It is your responsibility to provide us with your insurance information. Please be sure to bring your current insurance cards with you to your appointment. We will need this insurance information even if your inquiry is due to a work, auto, or personal injury. We accept Medicare, Medicare Assignment, and Medical Assistance, as well as private insurance. Please be sure to confirm with your insurance company as to your covered benefits, in-plan providers, and your co-pay and co-insurance responsibilities.

**Patient Financial Responsibility:** Your insurance may dictate that we collect co-payments, deductibles, and co-insurance, which is not subject to discounts and adjustments. Appropriate adjustments will be made to your account should we hold a contract with your insurance company. You may also be responsible for 1) denied claims, 2) partial payment such as the health plan's arbitrary determination of "usual and customary" rates, and 3) non-covered services.

**Co-payments:** Payment is due at the time of service at every appointment. We accept cash or check, as well as major credit cards/debit cards. These include: Visa, MasterCard, American Express, and Discover. **NOTE: Any payment made with a credit or debit card will be subject to a service fee charge.**

**Workman's Compensation & Auto or Personal Injury Claims:** You will need to provide us the proper filing information for your claim (correct address and claim number) at the time of your appointment.

**Self-Pay Agreements:** Our office does accept self-pay patients. At the time of each visit you will need to provide a \$25 payment, which is deducted from your final bill. In addition, a monthly payment plan will be established, with the monthly payment amount established at the first appointment.

**Referrals:** Many insurance companies will not pay for services rendered by a specialist without a referral. It is the responsibility of the patient to obtain any referral that is required by the health insurance plan.

**Delinquent Accounts:** All accounts must be satisfied within **90 days** unless arrangements have been made with our Billing Department. A prior arrangement for a regular scheduled payment plan is required. If you have a financial hardship, a copy of your most recent tax return is required. We may reschedule appointments or discontinue our relationship with you should bills go unpaid and no attempt has been made to reconcile the account.

**Overdue Accounts:** Overdue accounts for collection may be subject to a monthly 1.5% late fee charge, added to the overdue balance. If the account is sent to our collection agency, 34% of the balance due will also be added to the account balance due.

**NSF Fee:** There is a \$35.00 service charge for any returned check.



*I have read, understand, and agree to this financial policy. Also, I am aware that I am responsible for all charges incurred. I further agree that any and all monies paid directly to me by my insurance carrier or as a settlement for a workman's compensation, personal, or auto accident claim are owed to Valley Neuro/Microneurosurgery, S.C. up to the amount of payment in full of medical expenses I incurred and promise that I will pay Valley Neuro/Microneurosurgery, S.C. those monies due that I have been paid directly by my insurance company, workman's compensation, personal, or auto accident claim. I am also liable for all legal expenses incurred by Valley Neuro/Microneurosurgery, S.C. that may occur in collecting monies due Valley Neuro/Microneurosurgery, S.C. by me for medical treatment I have received.*

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*Patient or Responsible Party*

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*Date*