ADVANCE REGISTRATION INFORMATION (Please Print)

Appointment Date: _____

Dr. David M. Jones

PATIENT: _____ Sex: _____ Date of Birth: _____ Age: _____
(Last) (First) (Middle) (Maiden)

Address (Not P.O. Box #) _____ City/State/Zip _____

Mailing Address (if different from above) _____

S.S. # _____ Dr. Lic. # _____ Home # _____

Marital Status _____ Email _____ Cell # _____

Employer _____ Business # _____

Occupation _____ How long employed there: _____

SPOUSE OR PARENT INFORMATION:

Name _____ Relationship to patient _____ Spouse Date of Birth _____

Address if different from patient's _____ Spouse Cell # _____

Employer _____ City/State/Zip _____

Social Security No. _____ Occupation _____ Business # _____

Who may we contact if we need to change an appointment and cannot reach you? (Someone other than spouse)

Name _____ Relationship to patient _____ Phone # _____

Address _____

Name of Family Physician: _____ Phone # _____

Please sign here to authorize copies of your medical reports to be sent to him/her: X _____

INSURANCE INFORMATION:

Primary Carrier: Name of Insurance Company _____ ID # _____

Policyholder's Name _____ Relationship _____

Secondary Carrier: Name of Insurance Company _____ ID # _____

Policyholder's Name _____ Relationship _____

WORKMANS COMP CLAIMS ONLY: DATE OF INJURY _____ DESCRIPTION OF ACCIDENT _____

_____

Give name, address, and phone # of employer that you were working for when accident occurred: _____

_____

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO ANY INSURANCE COMPANY WITH WHOM I HAVE MEDICAL OR SURGICAL BENEFITS FOR THE PURPOSE OF FILING A MEDICAL OR SURGICAL CLAIM:

X _____ Date: _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS IF ANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF THE AMOUNT APPROVED OR PAID BY MY INSURANCE COMPANY.

X _____ Date: _____

I ASSUME THE LEGAL OBLIGATION TO PAY DR. David M. Jones FOR SERVICES FURNISHED FOR MEDICAL CARE.

X _____ Date: _____

(MEDICARE ONLY) I HEREBY CLAIM ANY MEDICARE BENEFITS DUE FOR THESE SERVICES.

X _____ Date: _____

CONSENT FOR RELEASE OF
PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

_____

_____

_____

_____

Check all that may apply:

- ☐ All my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) take care of me
- ☐ Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payors

My consent will remain in effect as long as I am a patient of Piedmont Neurosurgery, P.A. unless and until I notify Piedmont Neurosurgery, P.A. in writing of any changes.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

PIEDMONT NEUROSURGERY, P.A.

NAME_____DOB_____APPT DATE_____

CHIEF COMPLAINT

Where is the pain/problem?_____

How long have you had this pain/problem?_____

How severe is the pain/problem_____

Does this pain/problem occur at a specific time?_____

Where were you at the onset of pain/problem?_____

What makes the pain/problem worse or better?_____

Is this pain/problem a work related injury?_____If so, date of injury_____

Is this pain/problem related to an auto accident?_____If so, date of accident_____

Is this pain/problem related to some other type of accident?_____If so, date of accident and explain_____

PAST MEDICAL HISTORY

Cancer_____	Heart attacks_____	Abnormal bleeding_____
Stroke_____	Hernia_____	Acute infections_____
Arthritis/gout_____	Venereal disease_____	Convulsions_____

Other_____

PAST SURGICAL HISTORY OR OTHER HOSPITALIZATIONS

_____

_____

_____

CURRENT MEDICATIONS

_____

_____

_____

ALLERGIES_____

_____

SOCIAL HISTORY:

Marital Status: Single_____ Married_____Separated_____Divorced_____Widowed_____

Use of alcohol: Never_____ Rarely_____Moderate_____Daily_____Use of tobacco: Never_____Previously, but quit_____Current packs/day_____Use of drugs:

Never_____Type/Frequency_____Are you:

Left_____Right_____handed?

FAMILY MEDICAL HISTORY

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
Father			
Mother			
Siblings			

PL. .SE COMPLETE THE BACK OF THIS FC. I ALSO

SYSTEM REVIEW:

*CONSTITUTIONAL SYSTEMS

Good general health lately.....No Yes
Recent weight change..... No Yes
Fever.....No Yes
Fatigue.....No Yes
Headaches.....No Yes

Eyes

Eye Disease or injury.....No Yes
Wear glasses/contact lens.....No Yes
Blurred or double vision.....No Yes
Glaucoma.....No Yes

*EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing.....No Yes
Earaches or drainage.....No Yes
Chronic sinus problem or rhinitis....No Yes
Nose bleeds..... No Yes
Mouth sores..... No Yes
Bleeding gums.....No Yes
Bad breath or bad taste.....No Yes
Sore throat or voice change.....No Yes
Swollen glands in neck.....No Yes

*CARDIOVASCULAR

Heart trouble.....No Yes
Chest pain or angina pectoris.....No Yes
Palpitation.....No Yes
Shortness of breath.....No Yes
Swelling of feet, ankles or hands....No Yes

*RESPIRATORY

Chronic or frequent coughs.....No Yes
Spitting up blood.....No Yes
Shortness of breath.....No Yes
Asthma or wheezing.....No Yes

*GASTROINTESTINAL

Loss of appetite.....No Yes
Change in bowel movements..... No Yes
Nausea or vomiting.....No Yes
Frequent diarrhea.....No Yes
Painful bowel movements.....No Yes
Constipation.....No Yes
Rectal bleeding or blood in stool....No Yes
Abdominal pain or heartburn.....No Yes
Peptic ulcer (stomach or duodenal).No Yes

*GENITOURINARY

Frequent urination.....No Yes
Burning or painful urination.....No Yes
Blood in urine.....No Yes
Change in force of strain.....No Yes
Incontinence or dribbling.....No Yes
Kidney stones.....No Yes
Sexual difficulty.....No Yes
Male-testicle pain.....No Yes
Female-pain with periods.....No Yes
Female-irregular periods.....No Yes
Female-vaginal discharge.....No Yes
Female-#pregnancies____#miscarriages____
Female-date of last pap smear_____

*MUSCULOSKELETAL

Joint Pain.....No Yes
Joint stiffness or swelling.....No Yes
Weakness of muscles or joints....No Yes
Muscle pain or cramps.....No Yes
Back pain.....No Yes
Cold extremities.....No Yes
Difficulty walking..... No Yes

*INTEGUMENTARY(skin, breast)

Rash or itching.....No Yes
Change in skin color.....No Yes
Change in hair or nails.....No Yes
Varicose veins.....No Yes
Breast pain.....No Yes
Breast lump.....No Yes
Breast discharge.....No Yes

*NEUROLOGICAL

Frequent or recurring headaches.No Yes
Light headed or dizzy.....No Yes
Convulsions or seizures..... No Yes
Numbness or tingling sensation...No Yes
Tremors.....No Yes
Paralysis.....No Yes
Stroke..... No Yes
Head injury..... No Yes

*PSYCHIATRIC

Memory loss or confusion.....No Yes
Nervousness.....No Yes
Depression.....No Yes
Insomnia.....No Yes

*ENDOCRINE

Glandular or hormone problem..No Yes
Thyroid disease.....No Yes
Diabetes.....No Yes
Excessive thirst or urination.....No Yes
Heat or cold intolerance.....No Yes
Skin becoming dryer.....No Yes
Change in hat or glove size... No Yes

*HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts.....No Yes
Bleeding or bruising tendency...No Yes
Anemia.....No Yes
Phlebitis.....No Yes
Past transfusion.....No Yes
Enlarged glands.....No Yes

*ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin.....No Yes
Morphine, Demerol or other narcotics.....No Yes
Novocaine or other anesthetics.....No Yes
Aspirin or other pain remedies.....No Yes
Tetanus antitoxin or other serums.....No Yes
Iodine, methiolate or other antiseptic.....No Yes
Other drugs/medications_____

Known food allergies_____

OFFICE USE ONLY

Doctor **Date**

PIEDMONT NEUROSURGERY, P.A.

Eastway Plaza Box 108
1899 Tate Blvd, SE, Suite 2108
Hickory, NC 28602
(828) 327-6500

Name: _____ **Appt Date/Time:** _____

Please **BRING** the following items to your appointment:

- Enclosed forms **FULLY** completed
- All health insurance cards and driver's license/photo ID
- Current **MEDICATIONS** and/or complete list of all medications - MUST include drug name, strength, and dosage. (ex: Lortab 7.5 mg tablet, 1 every 4-6 hours as needed)
- Current **X-RAYS** and/or **MRI's** on disc/CD (An order will be enclosed if additional x-rays were ordered)

YOUR APPOINTMENT COULD BE CANCELLED OR RESCHEDULED IF YOU DON'T BRING THESE ITEMS

You will be required to pay any deductible, co-insurance, and/or co-pays at the time of services.
Please contact the Office Manager prior to your appointment with any questions.

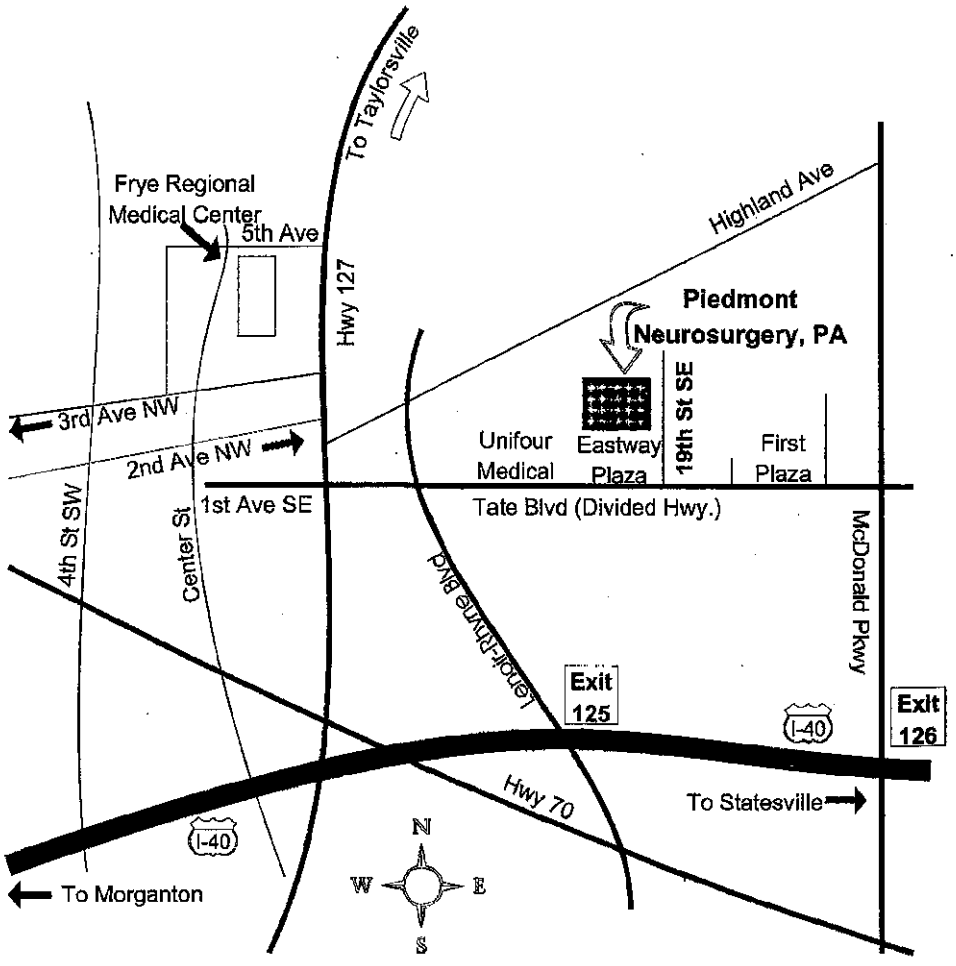
For everyone's consideration, we ask that you notify our office as soon as possible should you need to cancel or change your appointment. - Thank you.

From Lenior: Take Hwy 321 South to I-40 East (then follow Morganton directions below).

From Morganton or Asheville: Take I-40 East to Exit 126 (McDonald Pkwy). At top of ramp, turn left. Go approx 2 miles to intersection of Tate Blvd and McDonald Pkwy. Turn left on Tate Blvd. Travel approx 1.5 miles turn right on 19th St. SE. Turn Left into Eastway Plaza. We are on the 2nd Floor.

From Taylorsville: Take Hwy 16 South to I-40 West (then follow Statesville directions below).

From Statesville, or Winston-Salem: Take I-40 West to Exit 126 (McDonald Pkwy). At top of ramp, turn Right. Go approx 2 miles to intersection of Tate Blvd and McDonald Pkwy. Turn left on Tate Blvd. Travel approx 1.5 miles turn right on 19th St. SE. Turn Left into Eastway Plaza. We are on the 2nd Floor.



You can dowload and view forms from our website @ www.piedmontneurosurgery.com