Mercy Clinic Neurosurgery

PLEASE PRINT Today's Date________________

PATIENT'S NAME:

Last First Middle Initial

Address - Street or Box number

City State Zip

HOME PHONE (____)_________________ CELL (_____)_______________________

E-Mail ADDRESS ____

PRIMARY INSURANCE INFORMATION

Name of Ins. ____

Insured: _______________________________Insured's Date of Birth____/___/_______

Relationship to Insured ___________ Insured Social Security ______________________

Insured Employed by:____

Insured's Employer's Address____

Policy #____

Group #____

Is condition related to automobile

Accident? _____________________________________

Date of injury____________ State in which accident occurred___________________

Name and address of parties & persons liable

____

Name & address of insurance co.____

SECONDARY INSURANCE INFORMATION

Name of Ins.____

Insured____

Soc. Sec. No.____

Policy #____

Group Name____

Relationship to Insured____

WORKERS COMPENSATION CLAIM ONLY

Employer at time of injury_____________________________ Date of injury________

Address____

Phone (____)_________________ State in which injury occurred____________

Claim no. ___________________ Last day worked_____________________

Workman's compensation insurance carrier ___________________________

Address of carrier____

Primary care physician ___________________________
Last Name First Name

Referring physician ____________________________
Last Name First name

Date of Birth ______/_______/______ Age _______

Gender: M F Marital Status _____________

Social Security No. ___________________________

Employer Name: ______________________________

Employer Address:____________________________

Employer Phone No.____________________ext._____

Occupation: _________________________________

Employment Status:___________________________

If Married Name of Spouse ______________________

Spouse's Date of Birth: _________________________

Spouse's Employer: ___________________________

Emergency Contact:____________________________

Phone No.______________________________

Relationship:_________________________________

Local Pharmacy ______________________________

Phone No. ______________________________

Mail Order Pharmacy Name ______________________

Phone No. ______________________________

Patient Demographics

Mercy Clinic Neurosurgery is participating in Meaningful Use, a new nationwide initiative to improve the health of our nation. To better identify possible disparities in access and quality of healthcare based on race and ethnicity on a nation level, we are required to ask the following demographic questions:

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Prefer not to report

Ethnicity:
- ☐ Bosnian
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer not to report

Preferred Language:
- ☐ Bosnian
- ☐ English
- ☐ Sign Language
- ☐ Spanish

I authorize my insurance company/Medigap carrier to make payment directly to Mercy Clinic Neurosurgery for medical care rendered to me. However, I assume full responsibility for this bill. I am also responsible for collection agency/attorney fees, and court costs which may result from nonpayment or untimely payment for medical care rendered to me. I authorize Mercy Clinic Neurosurgery to release all medical information about me to my insurance company/Medigap carrier in order to determine benefits payable for related services. I also give Mercy Clinic Neurosurgery permission to release/obtain any information required in the course of examination or treatment of me. In addition, I hereby authorize the release of all applicable physicians and such other health care practitioners or organizations who/which will be providing subsequent monitoring of care or treatment in connection with care provided by any facility of Mercy

____ ____________________

Signature of Patient or Guardian if Minor **Date**

Patient Name: ____________________________ **Date of Birth:**___________**Date of Visit:** _____________

Referring Physician__________________________ **Primary Care Physician**_________________________

What is the main problem/symptom that leads you to seek care?________________________________

____

When did your problem begin? Is it constant, or does it "come and go"? Were you involved in an injury accident of some kind?____

____

Where is your problem located? ____

What body parts are affected?____

How severe is your problem/symptom today? ____

Describe it. ____

What circumstances, activities, or positions worsen your problem/symptom?_____________________

____

What circumstances, activities, or positions lessen your problem/symptom?_____________________

____

Do you have any other symptoms that may be related to your main problem? (i.e., numbness, tingling, weakness)____

____

What diagnostic testing has been done within the past year for your current problem?______________

____

What is your understanding of these results?____

____

Have you seen any other physicians regarding this problem? If so, please describe treatments prescribed and their effects on you.____

____

Describe any recent physical therapy.____

____

Patient Name: ____________________________ **Date of Birth:**___________**Date of Visit:** _____________

Vitals

Please list your weight ____________ **lbs. and height** ____________ **B/P (Office only)** _______________

Allergies

Drug/Non-Drug Allergy	Allergic Reaction

Medications List

Medication Name (Please include over the counter medications and supplements, vitamins.)	Strength / Dose (mg)	Number of pills per dose	Number of times Per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Patient Name: ____________________________ Date of Birth:___________Date of Visit: _____________

Past Medical History

Diabetes	_____Yes	____No		Emphysema or COPD	____Yes	____No
High Blood Pressure	_____Yes	____No		Hx of Infection	____Yes	____No
Stroke	_____Yes	____No		Depression	____Yes	____No
Coronary Artery Disease	_____Yes	____No		Arthritis	____Yes	____No
Heart Attack	_____Yes	____No		AutoImmune /Rheumatoid	____Yes	____No
Congestive Heart Failure	_____Yes	____No		Dementia (Alzheimer's etc.)	____Yes	____No
Peripheral Vascular Disease	_____Yes	____No		Ulcers	____Yes	____No
Seizures	_____Yes	____No		Liver Disease / Hepatitis	____Yes	____No
Bleeding Disorder	_____Yes	____No		High Cholesterol	____Yes	____No
HIV	_____Yes	____No		Irritable Bowel Syndrome	____Yes	____No
Rheumatic Fever	_____Yes	____No		Glaucoma	____Yes	____No
Kidney Stones	_____Yes	____No		Osteoporosis	____Yes	____No
Asthma	_____Yes	____No		Cancer	____Yes	____No
Anxiety	_____Yes	____No		Other Illness:		
Thyroid Disease	_____Yes	____No				

Surgical History/Hospitalizations

Previous Surgeries, Hospitalizations, and / or Serious Injuries	Year
____	___________
____	___________
____	___________
____	___________
____	___________

Family History

	Living	Deceased	Significant Illnesses
Mother	☐	☐	
Father	☐	☐	
Sister(s)	☐	☐	
Brother(s)	☐	☐	

Patient Name: ___________________________ **Date of Birth:**___________**Date of Visit:** _____________

Patient Social History

Use of Alcohol:	___Never ___Rarely ___Moderate ___Daily
Use of Drugs:	___Never ___Yes, Type/Frequency______________________
Use of Tobacco:	___Never ___Previously, but quit When? _____ Current Packs/Day_____
Occupation:	____
Exercise:	___No ___Yes, Type/Frequency________________________________
Marital Status:	___Single ___Married ___Separated ___Divorced ___Widowed
Religion:	Type____

Review of Systems – Are you having any of the following symptoms today?

Tired/Fatigue	____Yes	____No		Nausea	____Yes	____No
Fever	____Yes	____No		Vomiting	____Yes	____No
Unexpected Weight Change	____Yes	____No		Difficulty Controlling Urine	____Yes	____No
Eye Pain	____Yes	____No		Frequency in Urination	____Yes	____No
Blurred Vision	____Yes	____No		Burning with Urination	____Yes	____No
Double Vision	____Yes	____No		Back Pain	____Yes	____No
Sore Throat	____Yes	____No		Neck Pain	____Yes	____No
Runny Nose	____Yes	____No		Arthritis	____Yes	____No
Sinus Problems	____Yes	____No		Dizziness	____Yes	____No
Hearing Problems	____Yes	____No		Headaches	____Yes	____No
Difficulty Swallowing	____Yes	____No		Numbness	____Yes	____No
Chest Pain	____Yes	____No		Weakness	____Yes	____No
Palpitations	____Yes	____No		Bruises/Bleeds Easily	____Yes	____No
Cough	____Yes	____No		Nervous/Anxious	____Yes	____No
Wheezing	____Yes	____No		Skin Rash:__________________	____Yes	____No
Shortness of Breath	____Yes	____No		Where	____Yes	____No
Coughing Up Blood	____Yes	____No		Skin Spot:	____Yes	____No
Abdominal Pain	____Yes	____No		Where____________________	____Yes	____No
Constipation	____Yes	____No		Open Wounds	____Yes	____No
Diarrhea	____Yes	____No			____Yes	____No

Please list all Specialist Physicians you are currently following with:		
Type of Specialist	**Physician's Name**	**Reason for seeing the specialist**

PHI Communication Form

Patient Identification

Printed Name:______________________________________ Date of Birth: _________________________

Address: ____ Last 4 digits of SSN: ___________________

____ Telephone: ___________________________

I,_______________________________________, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below.

Authorized person(s) to receive **verbal** information regarding the above patient's care:

___________________________________	_______________________________	_________________
Printed Name	Relationship to Patient	Telephone
___________________________________	_______________________________	_________________
Printed Name	Relationship to Patient	Telephone
___________________________________	_______________________________	_________________
Printed Name	Relationship to Patient	Telephone

Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record.

Mercy will not release paper or electronic copies of your medical record to any one including those listed above unless an ***Authorization for Use and Disclosure of Protected Health Information*** form is completed or Mercy is already permitted by law to do so.

Mercy may still speak to other persons not listed on this form about your care if otherwise permitted by law.

I understand I may revoke this authorization at any time and Mercy will cease discussing my Protected Health Information with the above person(s) upon receipt, unless otherwise relied upon or if Mercy is not otherwise required by law to share information with the above person(s).

Patient or Legal Personal Representative:_____________________________ Date:__________
Signature

Patient or Legal Personal Representative:_____________________________
Printed Name

Authority of Personal Representative:________________________________

Patient Name:
MRN#:
Date of Birth:

Directions to

Mercy Clinic Neurosurgery
10012 Kennerly Rd
Suite 400
St. Louis, MO 63128
314-543-5999

From I-55 South: Take the I-270/I-255 exit - EXIT 196 - toward CHICAGO/KANSAS CITY. Merge onto I-270 N via EXIT 196B on the LEFT toward KANSAS CITY. Take the MO-21 S exit - EXIT 2 - toward HILLSBORO. Turn LEFT onto TESSON FERRY RD MO-21. Turn RIGHT onto SCHUESSLER RD. Immediately on your right you will see the Mercy Physicians Office Center Building and Parking garage. We are on the 4TH floor of the Physicians Office Center.

From I-44: Merge onto I-270 S via toward MEMPHIS. Merge onto TESSON FERRY RD/MO-21 S via EXIT 2 toward WEST BEND DR. Turn RIGHT onto SCHUESSLER RD. Immediately on your right you will see the Mercy Physicians Office Center Building and Parking garage. We are on the 4TH floor of the Mercy Physicians Office Center.

From I-70 East: Merge onto I-255 S toward MEMPHIS (Crossing into MISSOURI). Merge onto I-270 N. Take the MO-21 S exit - EXIT 2 - toward HILLSBORO. Turn LEFT onto TESSON FERRY RD/MO-21. Turn RIGHT onto SCHUESSLER RD. Immediately on your right you will see the Mercy Physicians Office Center Building and Parking garage. We are on the 4TH floor of the Physicians Office Center.

From I-70 West: Merge onto I-70 E/US-40 E. Merge onto US-40 E/US-61 S via EXIT 210A toward CHESTERFIELD/FOREST PARK. Stay STRAIGHT to go onto US-40 E/US-61 S. Merge onto I-270 S via EXIT 25 toward MEMPHIS. Merge onto TESSON FERRY RD/MO-21 S via EXIT 2 toward WEST BEND DR. Turn RIGHT onto SCHUESSLER RD. Immediately on your right you will see the Mercy Physicians Office Center Building and Parking garage. We are on the 4TH floor of the Mercy Physicians Office Center.

From Illinois: Take 255 South across the JB Bridge. Exit at TESSON FERRY RD MO-21 and turn LEFT. Turn RIGHT onto SCHUESSLER RD. Immediately on your right you will see the Mercy Physicians Office Center Building and Parking garage. We are on the 4TH floor of the Mercy Physicians Office Center.

Parking: The easiest access to our office is parking in the Mercy Physicians Office Center garage on the 4th level. There is also parking on a flat lot in front of the Mercy Physicians Office Center building.