Tulane DOCTORS
Healing People.
Defining Medicine.

Patient Name: _____

Address: _____
Street City State Zip Code

Primary Phone #:_____ ☐Home ☐Cell ☐Other _____

Secondary Phone # _____ ☐Home ☐Cell ☐Other _____

Date of Birth: _____ **Gender:** ☐Female ☐Male **Age:** _____ **Race:** _____

Marital Status: _____ **Patient's Social Security #:** _____

e-mail address: _____

Referring Physician: _____ **Phone #:** _____

Patient's Employer: _____ **Occupation:** _____

Employer's Address: _____

Employment Status: ☐Full Time ☐Part Time ☐Self Employed ☐Retired

Pharmacy Name: _____ **Phone Number:** _____

Pharmacy Address: _____

Next of Kin/Emergency Contact Information

Name: _____ **Relationship:** _____

Address: _____

Primary Phone #:_____ ☐Home ☐Cell ☐Other _____

Secondary Phone # _____ ☐Home ☐Cell ☐Other _____

PLEASE HAVE YOUR INSURANCE CARD AND PHOTO ID AVAILABLE TO COPY

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Arrival Notice

All patients must arrive 10-15 minutes before scheduled appointment time for completion of new patient information. Patients that show up 15 minutes past your scheduled appointment time will result in the rescheduling of your appointment.

MRIs

If an MRI is required for your visit, you must have the correct disc and MRI report with you to be checked in and seen. If disc is not present, your appointment will be rescheduled.

Thank you for your understanding and for choosing Tulane Neurosciences for your medical needs.

TULANE UNIVERSITY CENTER FOR CLINICAL NEUROSCIENCES
NEW PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: ____/____/_____ **AGE: _____** **HEIGHT: _____** **WEIGHT: _____**
MO DAY YEAR

REASON FOR THE VISIT: _____

ANY INJURIES TO THE SPINE OR BRAIN? _____

PAST MEDICAL HISTORY: Please circle

Heart Attack	Cancer	Hearing Loss	Alcoholism	High Cholesterol	Anemia	Mental Illness	Asthma
Migraines	Glaucoma	Arthritis	Kidney Disease	Liver Disease	Stroke	Hay Fever	Vertigo
High Blood Pressure	Bleeding Problems	Thyroid Disease	Blood Clots	Problems with Anesthesia	Diabetes	HIV	STD
Emphysema	Osteoporosis	Hemophilia					

FAMILY HISTORY:

FAMILY MEMBER	AGE	IF NOT ALIVE, WHAT WAS AGE OF DEATH?	HEALTH PROBLEM OR CAUSE OF DEATH
MOTHER			
FATHER			
SISTER(S)			
BROTHER(S)			

VACCINATIONS:
FLU- Y/N DATE OF LAST IMMUNIZATIOIN: _____ PNEUMONIA -Y/N DATE OF IMMUNIZATION: _____

ALLERGIES: _____

PAIN LEVEL RIGHT NOW- PLEASE CIRCLE:

SURGICAL HISTORY and DATES:
1._____ 2._____

3._____ 4. _____

DO YOU SMOKE? YES NO IF YES, HOW MANY CIGARETTES DO YOU SMOKE PER DAY? _____
DO YOU CONSUME ALCOHOL/BEER? YES OR NO IF YES, HOW MANY DRINKS DO YOU HAVE PER DAY? _____

ON THE OTHER SIDE OF THIS PAGE, PLEASE LIST ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING VITAMINS AND OVER THE COUNTER DRUGS

PLEASE LIST ALL OF THE MEDICATIONS AND YOU ARE CURRENTLY TAKING INCLUDING VITAMINS AND OVER THE COUNTER DRUGS:

_____

_____

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Tulane DOCTORS
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Review of Systems

101 Judge Tanner Blvd Suite 402 Covington, LA 70433
tel. 985-951-3222

Name _____ Date _____

Please check off the medical condition(s) below which apply to you either now or in the past.

Cardiovascular
- ☐ Chest pain/Pressure
- ☐ Fainting
- ☐ Heart Attack
- ☐ Heart Defect
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Leg Swelling

Constitutional
- ☐ Altered Taste/Smell
- ☐ Cancer
- ☐ Change in Appetite
- ☐ Dermatologic Disorder
- ☐ Excessive Sleepiness
- ☐ Fatigue
- ☐ Fever
- ☐ Psychiatric Problems
- ☐ Recent Sore Throat
- ☐ Sleep Apnea
- ☐ Weight Loss or Gain

Ear, Nose, & Throat
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Ringing in Ears
- ☐ Sinus Disease
- ☐ Trouble Swallowing

Eyes
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Galucoma
- ☐ Macular Degeneration
- ☐ Peripheral Vision Issue
- ☐ Visual Impairment

Gastrointestinal
- ☐ Black Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall Bladder Problems
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Vomiting

Skin
- ☐ Birth Marks
- ☐ Psoriasis
- ☐ Skin Rashes
- ☐ Melanoma

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Trouble Breathing
- ☐ Tuberculosis
- ☐ Wheezing

Musculoskeletal
- ☐ Connective Tissue Disorder
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Joint Pain
- ☐ Joint Replacement
- ☐ Joint Swelling

Genitourinary
- ☐ Blood in Urine
- ☐ Change in Habits
- ☐ Infections in Urine
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Loss of Control
- ☐ Painful Urination
- ☐ Urinary Urgency
- ☐ Vaginal Bleeding

Hemilymphatic/ Endocrine
- ☐ Anemia
- ☐ Blood Disorder
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Dry Eyes/Mouth
- ☐ Endocrine Disorder
- ☐ Low Blood Sugar
- ☐ Lymph Node Swelling
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Pituitary Disorder
- ☐ Sickle Cell Disease
- ☐ Thyroid Disease

Neurological
- ☐ Balance Difficulty
- ☐ Choking
- ☐ Clumsiness
- ☐ Concussion
- ☐ Confusion
- ☐ Concentration Difficulty
- ☐ Dizziness
- ☐ Drooling
- ☐ Falls
- ☐ Hallucinations
- ☐ Headache
- ☐ Loss of Consciousness
- ☐ Memory Problems
- ☐ Muscle Twitching
- ☐ Nausea
- ☐ Numbness
- ☐ Personality Change
- ☐ Seizure
- ☐ Shooting Pains
- ☐ Smelling Difficulty
- ☐ Stroke
- ☐ Tasting Difficulty
- ☐ Tingling Sensation
- ☐ Vertigo
- ☐ Walking Difficulty
- ☐ Weakness

For Providers Only:
All others negative ☐
Initial _____

Tulane DOCTORS
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Spine Patient Intake Form

101 Judge Tanner Blvd Suite 402 Covington, LA 70433
tel. 985-951-3222

Name _____ Age _____ Date _____

Primary Care Physician _____ Who referred you here? _____

☐ Right-Handed? or ☐ Left-Handed?

What is the reason for your visit today?

_____

_____

What symptoms were you experiencing?

_____

_____

What caused this?

☐ Work Injury ☐ Auto Accident ☐ Other Injury ☐ Do Not Know

When did this first start?

_____

_____

When did it get worse?

_____

_____

Is it....?

☐ Getting Better ☐ Getting Worse ☐ Staying the Same

How often do you have these symptoms?

☐ Rarely ☐ Occasionally ☐ Daily ☐ Almost Constantly

Is the pain...?

☐ Severe ☐ Aching ☐ Shooting ☐ Dull ☐ Burning

Does the problem interfere with your...?

☐ Ability To Work ☐ Activities of daily living ☐ Enjoyment of life

Do you have any weakness? ☐ Yes ☐ No

If so, where? _____

_____

Do you have numbness? ☐ Yes ☐ No

Do you have a problem with balance? ☐ Yes ☐ No

If so, how long? _____

_____

Have you fallen due to your problem? ☐ Yes ☐ No

Have you lost bladder control recently? ☐ Yes ☐ No

Have you lost bowel control recently? ☐ Yes ☐ No

If back pain: Which hurts worse? ☐ Back ☐ Hip/Legs ☐ Equal

If neck pain: Which hurts worse? ☐ Neck ☐ Arms ☐ Equal

Do any of these activities make the problem better or worse?

Walking	☐ Better	☐ Worse	☐ No Change
Standing	☐ Better	☐ Worse	☐ No Change
Sitting	☐ Better	☐ Worse	☐ No Change
Lying Down	☐ Better	☐ Worse	☐ No Change
Bending	☐ Better	☐ Worse	☐ No Change
Bowel Movement	☐ Better	☐ Worse	☐ No Change
Coughing or Sneezing	☐ Better	☐ Worse	☐ No Change
Going from Sitting to Standing	☐ Better	☐ Worse	☐ No Change

Do you have any? ☐ Fever ☐ Unexpected Weight Loss ☐ Tumors ☐ Pain at Night

Do you use tobacco products? ☐ Yes ☐ No

Is there any one in your immediate family that has a spine condition? ☐ Yes ☐ No

Mark the treatments you have tried.

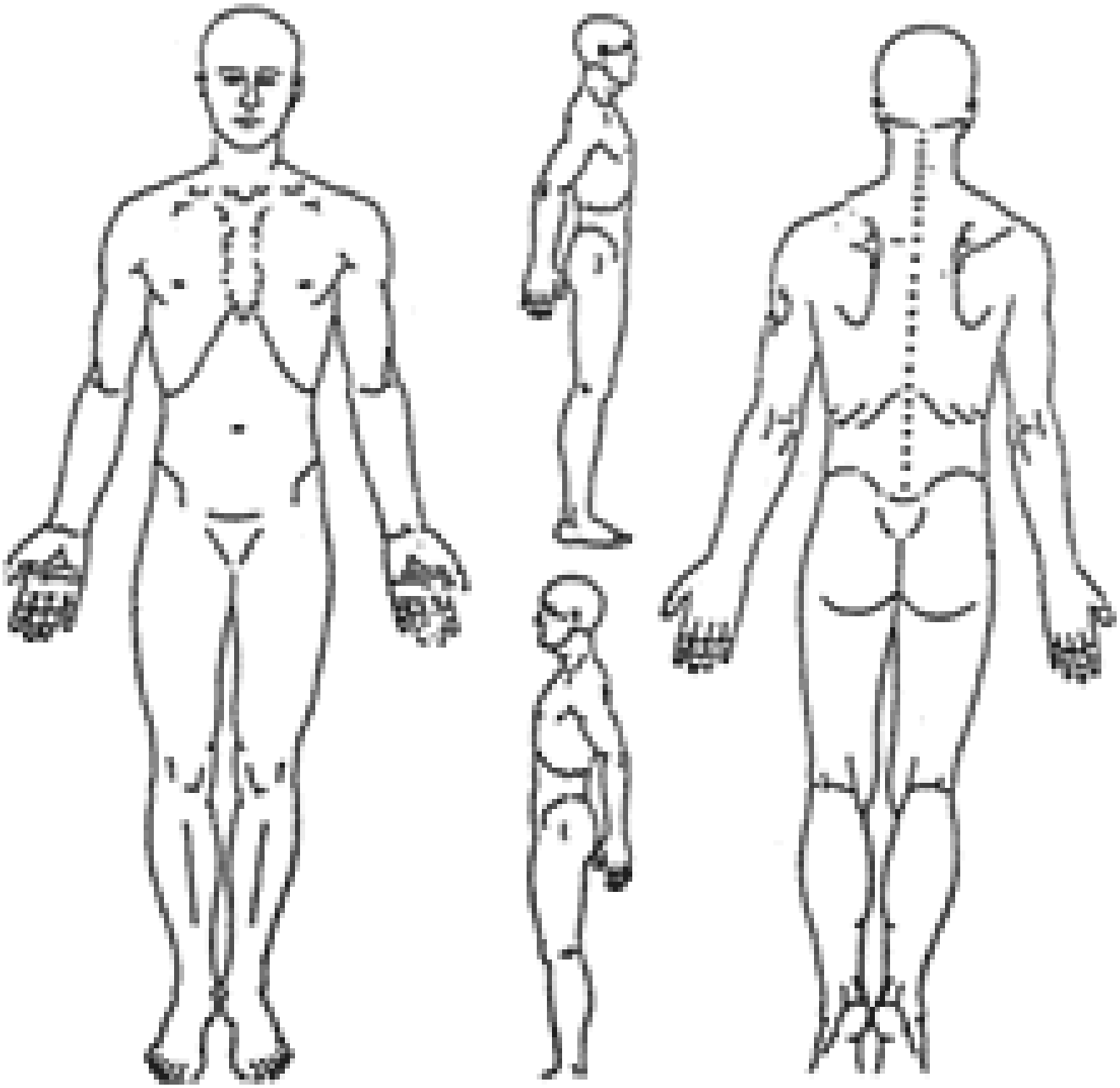
Physical Therapy ☐	Bracing ☐	Ibuprofen or Advil ☐
Chiropractic ☐	Acupuncture ☐	Other Medications ☐
Injections ☐	Exercise Therapy ☐	Surgery ☐
Pain Clinic ☐	Bed Rest ☐	Rhizotomy ☐

_____ _____

Name Date

PLEASE MARK YOUR SYMPTOMS ON THE PICTURE BELOW

XXX PAIN **OOO** NUMB or TINGLE **+++** BURNING



PAIN SCALE- Please circle below the pain level that most accurately describes your pain

IN LAST 24 hr	0	1	2	3	4	5	6	7	8	9	10
AT ITS WORST	0	1	2	3	4	5	6	7	8	9	10

Tulane University Medical Group
CONSENT AND RELEASE

ASSIGNMENT OF BENEFITS: I authorize direct payment to Tulane University Medical Group (TUMG), of all medical benefits, settlements, or judgments applicable to my treatment by TUMG physicians and other clinicians at the hospital or clinic. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked in writing by me. I understand that I am personally responsible for payment of all fees applicable to my treatment by TUMG physicians at the hospital or clinic, including copayments, deductibles, and fees for non-covered services, irrespective of other insurance coverage or other parties' responsibility to me for such fees. If unpaid balances are overdue and are referred for collection, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with collection.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, ACCEPTS THE TERMS THEREOF, AND HAS RECEIVED A COPY THEREOF.

RELEASE OF INFORMATION: I authorize TUMG and/or its physicians and other clinicians to disclose all or part of my medical or billing records to any insurance carrier or persons employed by such carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to group health plans for group insurance coverage, workman's compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release TUMG and its physicians and clinicians from any and all responsibility relative to the release of such information. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records: decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

_____ PATIENT NAME

_____ DATE OF BIRTH

_____ PATIENT SIGNATURE

_____ NAME OF AUTHORIZED AGENT, IF ANY

_____ SIGNATURE – IF SIGNED BY AUTHORIZED AGENT

_____ RELATIONSHIP TO PATIENT

_____ WITNESS NAME

_____ WITNESS SIGNATURE

_____ DATE OF SIGNING TIME

RX ELIGIBILITY CONSENT - By signing this consent form you are agreeing that Tulane University Medical Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I hereby provide informed consent to Tulane University Medical Group to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

INITIAL _____

CONSENT FOR TREATMENT DATE _____ TIME _____

I, OR _____ FOR _____ KNOWING THAT (I AM/HE OR SHE IS) SUFFERING FROM A CONDITION REQUIRING DIAGNOSIS AND/OR MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND HOSPITAL, MEDICAL, AND SURGICAL CARE AS NECESSARY IN THE JUDGMENT OF PHYSICIAN(S) IN CHARGE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE ME AS TO THE RESULTS OF EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE TULANE UNIVERSITY MEDICAL GROUP TO RETAIN OR DISPOSE OF ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY DURING MY TREATMENT, AND TO USE SUCH SPECIMENS OR TISSUES FOR SCIENTIFIC, EDUCATIONAL, OR RESEARCH PURPOSES, TO THE EXTENT THAT SUCH SPECIMENS AND TISSUES ARE NOT KEPT AT TULANE UNIVERSITY HOSPITAL AND CLINIC.

WITNESS _____ SIGNATURE _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

REFUSAL OF CONSENT FOR TREATMENT

I, _____ REFUSE TO CONSENT TO _____

_____ UPON _____

_____ I HAVE BEEN ADVISED OF THE CONSEQUENCES AND RISKS OF SUCH REFUSAL, AND HEREBY RELEASE THE PHYSICIANS, CLINICIANS, AND TULANE UNIVERSITY MEDICAL GROUP FROM LIABILITY FOR INJURIES ARISING FROM SUCH REFUSAL.

WITNESS _____ SIGNATURE _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

Tulane Neurosciences

101 Judge Tanner Blvd., Suite 402
Covington, LA 70433
Office: 985-951-3222

For your safety, our policy on authorizing the continuation of prescription medication is as follows without exception:

1. We only refill medications prescribed by physicians or physician assistants in this clinic. We will not authorize prescriptions by another physician.
2. We will not refill a prescription if you have not had an appointment within the last three months. Reasons for this policy include but are not limited to:
    a. We must be able to monitor your progress and response to medication on a regular basis to determine if the dose is appropriate for maximum effectiveness and safety.
    b. The Food and Drug Administration (FDA) may have discovered new potential toxicities or changed dosing recommendations or new studies may suggest a new approach.
3. It is important to report all medications you are taking to every provider you see to avoid potential drug interactions or organ damage. Carrying a medication list with you is a good idea.
4. It is your responsibility to notify your pharmacy for refills prior to running out. The pharmacy will need to send notification of your request for a refill via fax to our office at 985-951-3223 or e-scribe. Please allow 3 business days for your request to be processed.
5. NO narcotic refills will be authorized by our physicians or physician assistants after the 2 week postoperative period. If you continue to need pain medication after this period, you will be asked to provide the name of a pain management physician of your choice and a referral will be sent if needed.
6. As of October 1, 2014, the DEA requires that a hard copy prescription for a narcotic be written. Narcotic prescriptions cannot be faxed or called into a pharmacy.

Please acknowledge that you have read and understand the above policy on narcotic medication:

_____ _____

Patient's signature Date

_____

Please print patient's name

_____ _____

Witness (Neurosciences staff) Date

Tulane University Medical Group

Notice of Privacy Practices

I hereby acknowledge that I received a copy of the Tulane University Medical Group Notice of Privacy Practices.

Signature_____Date_____

Print Patient's Name_____

If not signed by the patient, please indicate relationship:_____

Print Name_____ Witness_____

Tulane University Medical Group

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Tulane University Medical Group must obtain a written authorization from a patient or their Personal Representative prior to releasing Protected Health Information, unless a legal exception applies. This form must be fully and completely filled out to be valid. A reasonable copying and handling charge may be charged for this request pursuant to La. R.S. 40:1165.1.

PATIENT AND RECIPIENT'S INFORMATION

I hereby authorize Tulane University Medical Group to release Protected Health Information on the patient listed below.

THE RECORDS OF: *(Patient's Information)*

Name: _____

DOB (MM-DD-YYYY): _____

Address: _____

Phone: _____

DELIVER TO: *(Recipient's Information)*

Name: _____

Address: _____

Phone: _____

Fax: _____

PURPOSE OF DISCLOSURE

☐ Treatment ☐ Personal ☐ Legal ☐ Insurance

SPECIFIC TREATMENT PERIODS

Specific treatment date or time period for which the information is requested:

☐ Single treatment date of _____.
☐ Period of treatment from _____ to _____.
☐ Any and all treatment encounters to date.

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Specific description of information to be used or disclosed. (*Check only those that apply or select All Records.)*

Medical Records

☐ Progress Notes
☐ Doctor's Orders
☐ Billing Records
☐ Nurse's Notes
☐ Lab Reports
☐ Immunization Records
☐ Other Medical Records:

(Please Describe) _____

_____

_____

Mental Health Records

☐ Mental Health Records
☐ Psychotherapy Notes

*This is the only item you may request on this authorization. You must submit another authorization for other items requested.

All Records

☐ Health Treatment and Billing Records

I hereby consent to release my HIV test results: _____ (Initial) I have a right to refuse to release my HIV test results, except where release is authorized by law without my consent.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing.
4. If the receiver is not a health care provider, the information may no longer be protected by federal privacy regulations.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee.
6. I may have a copy of this form after I sign it.

SIGNATURES

I have read the above and authorize the disclosure of the Protected Health Information as stated.

Signature of Patient/Personal Representative:	Date:
Print Name of Patient's Personal Representative (*Authority document must be attached*):	Relationship to Patient

OFFICE USE ONLY

RECEIVED DATE: _____

TIME: _____

ATTEMPTED TO CONTACT PATIENT DATES: **LEFT MSG**:

1. _____ Y / N
2. _____ Y / N
3. _____ Y / N

☐ Faxed ☐ Mailed ☐ General Counsel
☐ No record found/Letter Sent INITIALS
SEND DATE: _____ _____