Bianco Brain and Spine, LLCP

Today's Date:_____

Name:_____

Date of Birth:_____

Name of Doctor who referred you today: _____

List of Physicians

Primary Care Physician_____

Pain Management Physician_____

Neurologist_____

Cardiologist_____

Chief Complaints

Are You? □ Left Handed □ Right Handed

□ Headaches
□ Balance problems
□ Dizziness
□ Seizures
□ Visual Disturbances
□ Right facial pain
□ Left facial pain
□ Hearing Loss
□ Memory Loss
□ Nausea/Vomiting
□ Drop things (grip decrease)
□ Bowel or Bladder Incontinence
□ Difficulty Walking
□ Left arm pain
□ Left numbness and tingling
□ Left arm weakness
□ Right arm pain
□ Right numbness and tingling
□ Right arm weakness
□ Shoulder pain
□ Neck pain
□ Mid back pain
□ Low back pain
□ Left leg pain
□ Right leg pain
□ Left leg numbness/tingling
□ Right leg numbness/tingling
□ Left leg weakness
□ Right leg weakness

Any other complaint(s) not listed above _____

History and Physical

Date of onset: _____

Pain Frequency: □ Constant □ Daily □ Weekly □ Monthly □ Only with activity

Pain Level: **Choose one option** □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Briefly describe how your injury/ illness started or how it occurred: _____
_____
_____

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Previous Conservative Treatment/Testing

Please list any treatments you received below:

Rest _____ Medication_____ Weight Loss_____

Epidural Steroid Inj. _____ Oral Steroids_____ Physical/Water Therapy _____

Brace _____ Chiropractor_____ Massage Therapy_____

Current Medications

Medication Name:	Dosage:	How often do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? (Please List):_____

Past Medical History

□ Alcoholism	□ Anemia	□ Anesthetic Comp	□ Anxiety
□ Arthritis	□ Asthma	□ Autoimmune Problem	□ Birth Defects
□ Bleeding Disease	□ Blood Clots/DVT	□ Bowel Disease	□ Cancer
□ COPD	□ Depression	□ Diabetes	□ Gout
□ Heart Attack	□ Heart Disease	□ Hepatitis	□ High BP
□ High Cholesterol	□ HIV	□ Kidney/Blad Dis	□ Liver Disease
□ Lung/Resp Dis	□ Mental Illness	□ Migraines	□ Osteoporosis
□Parkinsons	□ Reflux/GERD	□ Seizures	□STD
□ Stroke/TIA	□ Seasonal Allergies	□ Suicide Attempt	□ Thyroid Problems
□ Ulcers			

□ **Other Disease**_____ □ **Type of Cancer**_____

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Past Surgical History

Starting with the most recent, please list in date order any surgeries you have had:

Date: _____ Operation: _____ Date: _____ Operation: _____

Date: _____ Operation: _____Date: _____ Operation: _____

Family History

☐ Alcoholism	☐ Anemia	☐ Arthritis
☐ Asthma	☐ Bleeding Disease	☐ Depression
☐ Diabetes	☐ Heart Disease	☐ Heart Disease
☐ Hypertension	☐ High Cholesterol	☐ Kidney/Bladder Disease
☐ Lung/Respiratory Disease	☐ Migraines	☐ Osteoporosis
☐ Seizures	☐ Severe Allergies	☐ Stroke
☐ Thyroid Problems	☐ **Other**_____	☐ **Type of Cancer**_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you live alone? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Occupation:_____

Job Status: ☐ Unemployed ☐ Employed full-time ☐ Employed part-time ☐ Retired ☐ Disabled

Risk Factors

Do you smoke? ☐ Never ☐ Currently ☐ Previously Yr started _____ Yr. Quit _____

Cigarette pks/per day _____ Cigarette/ pipes per wk _____ Chewing/ per week _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, type of alcohol consumed_____ How many drinks?_____ How often?_____

Are you at risk for HIV? ☐ Yes ☐ No

Do you use IV or elicit street drugs? ☐ Never ☐ Currently ☐ Previously Drug of choice? _____

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Review of Systems

Please Mark All That Apply

General

- ☐ Fevers
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue
- ☐ **Denies All**

Eyes

- ☐ Blurring
- ☐ Double vision
- ☐ Discharge
- ☐ Vision loss
- ☐ Eye pain
- ☐ Light sensitivity
- ☐ Halos
- ☐ **Denies all**

Ears/Nose/Throat

- ☐ Earache
- ☐ Ear Discharge
- ☐ Ringing in the Ears
- ☐ Nosebleeds
- ☐ Nasal Congestion
- ☐ **Denies all**

Cardiovascular

- ☐ Difficulty breathing at night
- ☐ Shortness of breath with exertion
- ☐ Swelling of hands or feet
- ☐ Lightheadedness with exertion
- ☐ **Denies all**

Gastrointestinal

- ☐ Excessive or Loss of Appetite
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Bloody or Dark/Tarry Stools
- ☐ Bowel Incontinence
- ☐ **Denies All**

Neurologic

- ☐ Difficulty with Concentration
- ☐ Inability to speak
- ☐ Frequent falls
- ☐ Brief paralysis
- ☐ Fainting
- ☐ Excessive daytime sleeping
- ☐ **Denies all**

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar
- ☐ Thoughts of suicide or violence
- ☐ Sense of great danger
- ☐ Frightening thoughts or sounds
- ☐ **Denies all**

Genitourinary

- ☐ Urinary Incontinence
- ☐ Urinary Urgency
- ☐ Urinary Frequency
- ☐ Nighttime Urination
- ☐ Inability to Empty Bladder
- ☐ Lack of Sexual Drive
- ☐ Trouble starting Urinary Stream

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HIPPA POLICIES

- I'm aware it is the office policy to restrict protected patient health information.
- I may refer to the office's Notice of Privacy Practices for detailed information.
- I understand Bianco Brain and Spine may provide information to caregivers and physicians currently involved in my care and to my insurance company for payment of claims.
- I authorize the following additional individuals to have access to my protected patient health information. I understand that if they are written on this list Bianco Brain and Spine will release information to them if they request as such.
- It is my responsibility to remove anyone from this list if they are no longer to receive information about my health status.

Name (Print)	Date of Birth	List any Restrictions (specific)	Relation to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Restrictions might include: Sexually Transmitted Diseases, Pregnancy, and Terminal/Mental/Behavioral Illness

May we leave confidential clinical information on your answering machine? ☐ Yes ☐ No

I have read and understand the above policies of the practice and agree to be bound by their terms.

SIGNATURE: _____ DATE: _____

Patient/Legally Authorized Representative

_____ _____

Printed Name Relationship to Patient

Bianco Brain and Spine, LLCP

Office Policies

- I hereby authorize my medical insurance companies to make payments directly to Bianco Brain and Spine.
- Additionally, I understand **any charges not paid by my insurance companies are ultimately my responsibility.**
- I understand that it is my responsibility to know what my co-pay is, my co-insurance is, as well what my deductible is.
- If I have **no medical insurance**, I understand payment is **due in full at the time of visit.** If you do not have the co-pay amount you will not be seen by the physician and your appointment will be rescheduled
- If my **injury occurred at school**, I'm aware I need a claim form filled out by an appropriate school official.
- If my **injury occurred because of a motor vehicle accident** or other personal injury I will be considered a self-pay patient. I understand Bianco Brain and Spine does not accept third party insurance or letters of protection from attorneys. We also do not accept Worker's Comp at any time.
- I am aware I will be asked for any outstanding balances, co-pays, co-insurances, or deductibles at the time of my visit. If I do not have these payments, I may be asked to reschedule my appointment with the physician.
- I understand I will be charged $30 for any returned checks.
- I am aware if I need surgery I will be asked for a **pre-payment** prior to my procedure and will need to make arrangements for the rest of the balance.
- I am aware that I am responsible for knowing which of my insurance primary, secondary, tertiary is and so on. I understand that Bianco Brain and Spine will not contact my insurance companies to request this information.

_____ _____

Printed Name Relationship to Patient

_____

Signature

_____

Date

Bianco Brain and Spine, LLCP

Prescription Medication and Refill Policy

A reminder to our patients…

- Unless surgery is performed by Dr. Bianco no narcotic prescriptions will be given.
- If you are a patient that has a surgical procedure by Dr. Bianco please read our policy regarding narcotics.
- Refill requests for medications prescribed by our office will be accepted **only from your selected pharmacy** during regular business hours. Business hours are Monday through Friday from 8:00am to 5:00pm. It is **your** responsibility to let us know if your pharmacy changes.
- If you need a refill on your medication**, please contact your selected pharmacy** for a refill request to be sent to our office. Please do not contact our office directly for refills as this will only delay the process.
- After discharge from the hospital please have the refills sent to our office instead of the discharging physician at the hospital. They will be unable to prescribe your medication.
- If your request is received after 3:30pm Monday through Thursday, or after 12:00pm on Friday, it will be processed the next business day. Please plan accordingly, **as no refills will be authorized on Saturday or Sunday.**
- **If you receive a prescription for pain medication from this office, you agree not to seek additional pain medications from any other physicians office unless you are referred by our office to that specific physician to take over management of you pain medications.**
- If you seek pain medications from other physicians while we are prescribing you narcotics you may be discharged as a patient from Bianco Brain and Spine. This policy is in place to provide you with the safest care possible.

Selected Pharmacy Information:

Pharmacy name: _____

Pharmacy address: _____

Pharmacy phone number: _____

I have read and understand the above policy.

Patients Printed Name: _____

Patients Signature: _____ Date_____