NORTHWEST BRAIN & SPINE

2115 NE Wyatt Court, #201 • Bend, OR 97701 • 541-585-2400

PATIENT INFORMATION

Social Security #: _____ Email: _____

Last: _____ First: _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Birth Date: _____

Marital Status: ☐ M ☐ W ☐ S ☐ D ☐ OTHER Gender: ☐ Male ☐ Female Ht: _____ Wt: _____

Primary Care Physcian: _____ Employer: _____

Emergency Name and Phone: _____ (___) _____

Different than above

RESPONSIBLE PARTY INFORMATION

(IF PATIENT IS A MINOR OR IF POWER OF ATTORNEY IS INVOLVED)

Last: _____ First: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Birth Date: _____

Marital Status: ☐ M ☐ W ☐ S ☐ D ☐ OTHER Gender: ☐ Male ☐ Female

Social Security Number: _____ Relationship to Patient: _____

Employer Name: _____ Employer Phone: (___) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Patient or Responsible Party Signature _____ Date: _____

eClinicalWorks
"Improving Healthcare Together"

The eClinicalWorks Patient Portal enables patients and doctors to communicate with one another over the Internet. Using a secure password, patients can access their physician's system to see their own confidential information including labs, diagnostics, statements and messages.

Would you like to be enabled for access to your Patient Portal? ☐ YES ☐ NO

MEDICAL INSURANCE

PRIMARY

Insurance Company Name: _____ Social Security Number: _____

Subscriber Last Name: _____ First Name: _____ Middle: _____

Subscriber Phone: ( ) _____ Subscriber Birth Date: _____ Gender: _____

Policy #: _____ Group #: _____

Copayment amount: _____ (Copayments are due at time of visit)

SECONDARY

Insurance Company Name: _____ Social Security Number: _____

Subscriber Last Name: _____ First Name: _____ Middle: _____

Subscriber Phone: ( ) _____ Subscriber Birth Date: _____ Gender: _____

Policy #: _____ Group #: _____

Is this appointment due to an on-the-job accident? ☐ YES ☐ NO Date of injury: _____
If yes, an 827 form will need to be filled out at your first visit.

Is this appointment due to a motor vehicle accident? ☐ YES ☐ NO Date of injury: _____
If yes, an MVA form will need to be filled out at your first visit.

AGREEMENT AND CONSENT

My signature acknowledges having read the following regarding my services at NW Brain & Spine:

- I authorize the release of my personal health information according to the Notice of Privacy Practices presented me.
- I assign to NW Brain & Spine my insurance company benefit payments for services received.
- To provide correct personal information prior to service or be financially responsible for insurance benefit denial.
- To pay for services received that my insurance company considers a non-covered benefit.
- To pay for services deemed by my insurance company as medically unnecessary.
- Insurance Co-payments at the time of service. Appointments will be rescheduled until Co-payment can be made at the time of service.
- I will pay Insurance Deductibles determined by my insurance company as patient responsibility or make payment plan arrangements prior to receiving services.
- To pay for forms, letters or paperwork requests prior to receiving requested documents.
- Repeated no-show or cancellations may result in no future appointments.

_____

Print Name Signature Date

NORTHWEST BRAIN & SPINE • PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____ Todays Date: _____

Reason for visit? _____ Height: _____ Weight: _____

If in pain, where exactly is your worst pain located? _____

How long have you had pain? _____ On a scale from 0 - 10, rate your pain: _____

Current or previous treatments: ☐ PT ☐ Chiropractic ☐ Other _____

CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

_____

_____

DAILY BLOOD THINNERS
(INCLUDING ASPIRIN): _____

WHAT DO YOU
TAKE FOR PAIN? _____

ALLERGIES:

_____

_____

LIST ALL PREVIOUS SURGERIES & DATES:

Date _____ Surgery _____

Date _____ Surgery _____

Date _____ Surgery _____

Date _____ Surgery _____

Date _____ Surgery _____

Date _____ Surgery _____

PLEASE CHECK ANY MEDICAL CONDITIONS THAT APPLY TO YOU:

☐ Diabetes	☐ Asthma	☐ Recurrent Falls	☐ Kidney Disease
☐ High Blood Pressure	☐ COPD	☐ Headaches	☐ Liver Disease
☐ Heart Disease	☐ Hypothyroid Disease	☐ Neuropathy	☐ Skin Conditions
☐ Heart Attack	☐ Gout	☐ Multiple Sclerosis	☐ Stomach Ulcers/Acid Reflux
☐ Stroke	☐ Muscle Weakness: Cause	☐ Rheumatoid Arthritis	☐ Raynaud's
☐ Peripheral Vascular Disease	☐ Arthritis	☐ Osteoperosis	☐ Anxiety/Depression
☐ Blood Clots	☐ Claustrophobia	☐ Parkinson's Disease	☐ Cancer (Specify Type): _____
☐ High Cholesterol	☐ Fibromyalgia	☐ Hepatitis	☐ Other: _____

PLEASE INDICATE ALL FAMILY HEALTH HISTORY(PLEASE CIRCLE):

Heart Disease	Kidney Disease	Epilepsy
Headaches	Thyroid	Respiratory Disease
Kidney Disease	Diabetes	Cancer (Specify Type): _____

Other: _____

Fathers Current Health Condition: _____ Age:_____	Mothers Current Health Condition: _____ Age:_____

Please circle one:
Married Single Divorced Widowed

Job Title: _____ Hobbies/Recreactions: _____

Do you drink alcohol? ☐ YES ☐ NO How much per day? _____ Per week? _____

Do you smoke? ☐ YES ☐ NO How many per day? _____ How many years? _____

Do you exercise? ☐ YES ☐ NO How many times per week? _____ How long per workout? _____