

Center For Neurological Surgery, A Medical Group, Inc.
Mark S. Schnitzer, M.D.

Surgery of the Nervous System and Spine
(714) 525-7177 (562) 698-2054

Patient Information

Patient's Name:	
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Patient's Date-of-Birth (mm/dd/yyyy):	
Patient's Social Security Number:	
Patient's Marital Status:	<input type="checkbox"/> Married, <input type="checkbox"/> Widowed, <input type="checkbox"/> Divorced, <input type="checkbox"/> Single
Patient's Street Address:	
Patient's City, State, Zip Code:	
Home Phone:	()
Patient's Employment Status:	<input type="checkbox"/> Full-time, <input type="checkbox"/> Part-time, <input type="checkbox"/> Retired, <input type="checkbox"/> Self-employed, <input type="checkbox"/> Student <input type="checkbox"/> Disabled, <input type="checkbox"/> Unemployed
Patient's Employer:	
Patient's Occupation:	
Work Phone:	()
Employer's Street Address:	
Employer's City, State, Zip Code:	
Name, Address and Best Phone Number of Individual to Contact in Case of Emergency:	
Whom may we thank for referring you to our offices?	

Center For Neurological Surgery, A Medical Group, Inc.
Mark S. Schnitzer, M.D.

Surgery of the Nervous System and Spine
(714) 525-7177 (562) 698-2054

INSURANCE INFORMATION
(Please fill-out completely)

Name of Patient:	
Name of Insured:	
Relationship to Patient:	
Patient's Date-of-Birth (mm/dd/yyyy):	
Patient's Social Security Number:	
<u>Name</u> and <u>Address</u> of Patient's Employer/School:	
Patient's <u>Work</u> Phone Number:	()
Patient's <u>Home</u> Phone Number:	()
Insurance Company <u>Name</u> and <u>Address</u> :	

DO YOU HAVE ADDITIONAL INSURANCE?	<input type="checkbox"/> Yes (complete next section) <input type="checkbox"/> No
--	--

Name of Insured:	
Relationship to Patient:	
Insurance Company <u>Name</u> and <u>Address</u> :	

Did your problem arise from an <u>auto accident</u> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did your problem arise from a <u>work injury</u> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is a <u>Lawyer</u> or <u>Law Suit</u> Involved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

We need to photocopy your Insurance card(s) and Driver's License

Center For Neurological Surgery, A Medical Group, Inc.
Mark S. Schnitzer, M.D.

Surgery of the Nervous System and Spine
(714) 525-7177 (562) 698-2054

**Authorization/Financial Responsibility Form
Assignment of Benefits/Release of Information**

Please read carefully before signing. Your signature is necessary for us to process all insurance claims and to insure payment of services rendered.

- I authorize the release of medical information necessary to obtain authorization for treatment from my insurance company and to process claims.
- I request that payment of authorized Medicare and/or authorized Medigap benefits be made to The Center For Neurological Surgery/Mark S. Schnitzer M.D. for any services furnished me by that physician or supplier. I permit a copy of this authorization to be used in place of the original and authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents any information needed to determine these benefits or the benefits payable for related services.
- I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to The Center For Neurological Surgery, and I authorize payment directly to them. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
- I understand that if I receive any payments due to The Center For Neurological Surgery or to Dr. Schnitzer, it is my responsibility/obligation to immediately remit the payments to them/him. I further realize that if I fail to do so, I am responsible for the bill in its entirety.
- If my insurance benefits are canceled, and I continue to receive services, I agree to pay all bills in full.
- I also agree to cooperate with my insurance company and to submit all forms they request. Should I fail to do so, and thus payment is denied, I agree to pay the bill in its entirety.

The undersigned, in consideration of the service to be rendered by The Center For Neurological Surgery/Mark S. Schnitzer M.D. to the patient named below hereby agrees to pay on demand, as if the same or in original obligation, all charges of said services and incidental incurred by said patient at the regularly established rates.

Insurance coverage does not necessarily mean full coverage, and I understand that I am personally responsible for all charges irrespective of insurance coverage in all charges are due and payable within 30 days of the services rendered.

I/We further agree that the account may be placed for collection when it becomes 30 days past due. I/We hereby knowledge that I/we have read the above, or have had the above read to me/us and I/we understand the terms of this agreement.

Patient's signature _____ **Date** _____

Insured's signature _____ **Date** _____

Center For Neurological Surgery, A Medical Group, Inc.
Mark S. Schnitzer, M.D.

Surgery of the Nervous System and Spine
(714) 525-7177 (562) 698-2054

Center For Neurological Surgery, A Medical Group, Inc.
History & Physical Exam
Mark S. Schnitzer, M.D.

Patient Name:	
Today's Date:	
Referring Doctor:	
Family Doctor:	

ID:

How old are you?	
Are you right handed or left handed?	
What is your race?	
What is your sex?	

Past Surgical History:

Brain Surgery?	Yes	No	
Spine Surgery?	Yes	No	
Heart Surgery?	Yes	No	
Cancer/Tumor Surgery or Biopsy?	Yes	No	
Any Other Procedures?	Yes	No	
Describe:			
Any Problems With Anesthesia?	Yes	No	
Any Blood Transfusions?	Yes	No	

Center For Neurological Surgery, A Medical Group, Inc.
Mark S. Schnitzer, M.D.

Surgery of the Nervous System and Spine
(714) 525-7177 (562) 698-2054

Past Medical History:

Neurological Disorder (Alzheimer's, Multiple Sclerosis, Myasthenia Gravis, Seizures, Stroke etc.)? Describe:	Yes	No	
Heart Attack?	Yes	No	
High Blood Pressure?	Yes	No	
Irregular Heart Beat?	Yes	No	
Cancer? Describe:	Yes	No	
Thyroid Disease?	Yes	No	
Lung Disease (Asthma, Emphysema, etc.)? Describe:	Yes	No	
Diabetes?	Yes	No	
Ulcers?	Yes	No	
Any Other Conditions? Describe:	Yes	No	

Medications & Allergies:

What Medications do you Take?		
Do you Take <u>Aspirin</u> Regularly (<u>Not Tylenol, Motrin, etc.</u>)?	Yes	No
Do You Carry Nitroglycerin For Chest Pain?	Yes	No
What are you <u>Allergic</u> to?		

Any Diseases Run In The Family?

Father:	
Mother:	
Siblings:	
Other:	

Center For Neurological Surgery, A Medical Group, Inc.
Mark S. Schnitzer, M.D.

Surgery of the Nervous System and Spine
(714) 525-7177 (562) 698-2054

Review Of Systems...Any Recent...

Fever?	Yes	No	
Weight Change?	Yes	No	
Eye/Vision Problems?	Yes	No	
Ear/Nose/Throat Problems?	Yes	No	
Chest Pain?	Yes	No	
Shortness of Breath?	Yes	No	
Nausea/Vomiting?	Yes	No	
Incontinence?	Yes	No	
Musculoskeletal Problems?	Yes	No	
Skin Problems?	Yes	No	
Seizures?	Yes	No	
Psychiatric Condition?	Yes	No	
Do You Feel Hot/Cold/Thirsty?	Yes	No	
Abnormal Bruising/Glands?	Yes	No	
Risks for HIV/AIDS?	Yes	No	

Social History:

Marital Status?	
How Far Did You Go in School?	
Type Of Work?	
Do You Ever Use Any Tobacco?	
Do You Ever Use Any Alcohol?	
Do You Ever Use Any "Recreational" Drugs?	

Center For Neurological Surgery, A Medical Group, Inc.
Mark S. Schnitzer, M.D.

Surgery of the Nervous System and Spine
(714) 525-7177 (562) 698-2054

History...Briefly Tell Me, **In Your Own Words, What Brings You In.**

What is the <u>MAIN</u> problem?	
When did it start?	
Where (on your body)?	
Continuous or Intermittent?	
When does it bother you?	
How bad is it? (1-10)	
Pain/Burning/Tingling/Weakness?	
What makes you Better? Worse?	
Anything else?	