Dani S. Bidros, M.D.
2222 Greenhouse Road, Suite 1100A
Houston, TX 77084
Phone: (281) 529-6626
Fax: (832) 288-5967

Dear New Patient:

Welcome to the neurosurgical practice of Dani Bidros, M.D. We promise you expert, compassionate care. It is a privilege to serve you.

I am a neurosurgeon, specializing in the diagnosis and surgery of the brain, spine, and peripheral nerves. Most of my patients are referred by other physicians, but I also accept referrals from my prior patients and workers compensation.

It is essential for you to bring with you on your first visit ALL available x-rays, imaging by MRI or CT related to your condition. The actual films or CD are essential, and a radiologist's report is NOT a substitute for the films themselves. You are RESPONSIBLE for bringing the CD with you to your appointment.

Please be sure to bring your insurance benefit ID card with you when you attend clinic. The charge for a new patient evaluation is $180 to $500, payable by cash, Visa, MasterCard or check at the time of the visit. We are happy to file insurance claims on your behalf at no charge.

- **Private Insurance**
  If you have a co-pay for your insurance, we will require that to be paid at the time of service.

  If you have a deductible on your plan instead of an office visit co pay AND have not met the deductible, you will be required to pay the office visit IN FULL depending on how much deductible you have left remaining.

- **Medicare ONLY**
  Medicare ONLY patients are responsible for 20% of Medicare's allowable fee at the time of service. (for all NEW PATIENTS the 20% would be NO MORE THAN $50.00)

- **Medicare AND Supplemental Insurance**
  If you have Medicare AND a supplemental insurance, you will not be required to pay anything at the time of the appointment AS LONG AS WE ARE PROVIDERS FOR YOUR SUPPLEMENTAL INSURANCE.

If you are unable to attend your clinic appointment, please advise one of our clinical team members as early as possible, and you will be given a new date and time. We try to be on time for our scheduled appointments, but unexpected emergency consultations and/or surgery sometimes disrupt our plans. Our staff will advise you if there are problems and will alter appointments to suit your convenience.

Please fill out the enclosed history and insurance forms completely and return it back to our office 48 hours PRIOR to your appointment or we reserve the right to reschedule your appointment.

This information is essential for your evaluation.

Sincerely yours,
Dani S. Bidros, M.D.

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DATE:_____

NAME:_____ ☐ SINGLE ☐ MARRIED ☐ WIDOW ☐ DIVORCED

SEX: ☐ M ☐ F BIRTHDATE:_____/_____/_____ SOCIAL SECURITY #:_____/_____/_____RACE:_____

LANGUAGES THAT YOU SPEAK:_____

ETHNICITY: (CIRCLE ONE) ☐ HISPANIC/LATINO OR ☐ NON-HISPANIC/LATINO

HOME PHONE #_____ CELL PHONE #_____ PAGER #_____

MAILING ADDRESS:_____ CITY_____STATE_____ZIP CODE_____

SPOUSE'S NAME:_____

SPOUSE'S SOCIAL SECURITY #: _____/_____/_____ BIRTHDATE: _____/_____/_____

E-MAIL ADDRESS:_____

EMERGENCY CONTACT_____RELATIONSHIP_____PHONE#_____
***NOT LIVING IN THE SAME HOUSEHOLD

PATIENT'S EMPLOYER:_____ WORK #_____

ADDRESS:_____ CITY:_____STATE_____ZIP CODE_____

IS THIS CASE IN LITIGATION?_____ IF SO, ATTORNEY'S NAME _____

PRIMARY INSURANCE:_____

POLICY HOLDER_____ POLICY #_____GROUP # _____

INSURED SOCIAL SECURITY_____ DATE OF BIRTH_____EMPLOYER_____

RELATIONSHIP TO PATIENT_____ EFFECTIVE DATE OF COVERAGE_____

INS. ADDRESS_____CITY_____STATE_____ZIP CODE_____

SECONDARY INSURANCE:_____

POLICY HOLDER_____POLICY #_____GROUP #_____

INSURED SOCIAL SECURITY_____DATE OF BIRTH_____EMPLOYER_____

RELATIONSHIP TO PATIENT_____EFFECTIVE DATE OF COVERAGE_____

INS. ADDRESS_____CITY_____STATE_____ZIP CODE_____

DANI S BIDROS, M.D.
WEST HOUSTON BRAIN AND SPINE

PATIENT'S SOCIAL HISTORY

WHAT IS YOUR AGE?_____

WHAT IS YOUR OCCUPATION?_____

ARE YOU RIGHT HANDED OR LEFT HANDED? (CIRCLE ONE)

ARE YOU SINGLE, MARRIED, SEPARATED, WIDOWED, OR DIVORCED? (CIRCLE ONE)

DO YOU HAVE ANY CHILDREN? YES OR NO. IF YES, HOW MANY?_____

WHAT IS YOUR HEIGHT?_____FEET _____INCHES

WHAT IS YOUR WEIGHT?_____POUNDS

DO YOU DRINK ALCOHOL? YES OR NO (HEAVY, MODERATE, NEVER, OCCASIONALLY) (CIRCLE ONE)

CAFFEINE USE? YES OR NO IF SO, WHAT TYPE AND HOW MUCH PER DAY?_____

DO YOU SMOKE:
- ☐ CURRENT, EVERYDAY — IF SO, HOW MUCH?
- ☐ CURRENT, SOMEDAY — IF SO, HOW MUCH?
- ☐ FORMER SMOKER — IF SO, WHEN DID YOU STOP?
- ☐ NEVER SMOKED

ADDITIONAL TOBACCO USE: CHEW, DIP, SNUFF, E- CIGARETTES OR VAPOR)? YES / NO
IF SO, WHAT AND HOW MUCH?_____

DO YOU HAVE A HISTORY OF USE OR ABUSE OF STREET DRUGS? YES OR NO IF YES, DESCRIBE:_____

WHAT IS THE HIGHEST LEVEL OF EDUCATION THAT YOU HAVE COMPLETED? (CIRCLE ONE)
(GRADE SCHOOL, HIGH SCHOOL, TRADE SCHOOL; ASSOCIATES; BACHELORS OR MASTERS DEGREE)

WHAT IS YOUR EMPLOYMENT STATUS? (CIRCLE ONE)
(FULL-TIME, PART-TIME, UNEMPLOYED, DISABLED, RETIRED, STUDENT)

ARE YOU WORKING AT THIS TIME? YES / NO. IF NO, DATE LAST WORKED?_____

PATIENT'S FAMILY HISTORY

IS THERE ANY HISTORY IN YOUR BLOOD-RELATED FAMILY MEMBERS OF: (PLEASE CIRCLE)

STROKE	☐ YES	☐ NO	IF YES, WHO:_____
HIGH BLOOD PRESSURE	☐ YES	☐ NO	IF YES, WHO:_____
CANCER	☐ YES	☐ NO	IF YES, WHO:_____
HEART DISEASE	☐ YES	☐ NO	IF YES, WHO:_____
KIDNEY DISORDERS	☐ YES	☐ NO	IF YES, WHO:_____
LUNG DISORDERS	☐ YES	☐ NO	IF YES, WHO:_____
BLEEDING DISORDERS	☐ YES	☐ NO	IF YES, WHO:_____
SEIZURES	☐ YES	☐ NO	IF YES, WHO:_____
DIABETES	☐ YES	☐ NO	IF YES, WHO:_____
NECK PAIN	☐ YES	☐ NO	IF YES, WHO:_____

BACK PAIN ☐ YES ☐ NO IF YES, WHO:_____
OTHER ☐ YES ☐ NO IF YES, WHO:_____

PATIENT'S PERSONAL MEDICAL HISTORY

DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL DISEASES OR CONDITIONS?

(PLEASE CIRCLE AND EXPLAIN)

ARTHRITIS PROBLEMS? YES / NO IF YES, DESCRIBE: _____
JOINT PROBLEMS? YES / NO. IF YES, DESCRIBE:_____
LUNG PROBLEMS? YES / NO. IF YES, DESCRIBE:_____
BLEEDING DISORDER? YES / NO. IF YES, DESCRIBE:_____
BLURRED OR DOUBLE VISION? YES / NO. IF YES, DESCRIBE:_____
CANCER? YES / NO. IF YES, DESCRIBE:_____
CHANGES IN YOUR SPEECH? YES / NO. IF YES, DESCRIBE:_____
DIABETES? YES / NO. IF YES, DESCRIBE:_____
DIFFICULTY HEARING? YES / NO. IF YES, DESCRIBE:_____
FAINTING SPELLS? YES / NO. IF YES, DESCRIBE:_____
MIGRAINES? YES / NO IF YES, DESCRIBE: _____
HEADACHES? YES / NO. IF YES, DESCRIBE:_____
HEAD INJURY? YES / NO. IF YES, DESCRIBE:_____
HEART DISEASE? YES / NO. IF YES, DESCRIBE:_____
HEPATITIS? YES / NO. IF YES, DESCRIBE:_____
HIGH BLOOD PRESSURE? YES / NO. IF YES, DESCRIBE:_____
ABDOMINAL PROBLEMS OR PAIN? YES / NO. IF YES, DESCRIBE: _____
BLADDER PROBLEMS? YES / NO. IF YES, DESCRIBE:_____
BOWEL PROBLEMS? YES / NO. IF YES, DESCRIBE:_____
NUMBNESS OR TINGLING? YES / NO. IF YES, DESCRIBE:_____
PERIPHERAL VASCULAR DISEASE? YES / NO. IF YES, DESCRIBE:_____
PSYCHIATRIC ILLNESS? YES / NO. IF YES, DESCRIBE:_____
SERIOUS CHILDHOOD ILLNESS? YES / NO. IF YES, DESCRIBE:_____
SEIZURES OR FITS? YES / NO. IF YES, DESCRIBE:_____
SERIOUS INFECTION? YES / NO. IF YES, DESCRIBE:_____
STROKE? YES / NO. IF YES, DESCRIBE:_____
TUBERCULOSIS? YES / NO. IF YES, DESCRIBE:_____
ULCERS? YES / NO. IF YES, DESCRIBE:_____
WEAKNESS? YES / NO. IF YES, DESCRIBE:_____
SURGICAL OR ANESTHETIC COMPLICATIONS? YES / NO. IF YES, DESCRIBE:_____

_____

DIFFICULTY REMEMBERING OR CONCENTRATING? YES / NO. IF YES, DESCRIBE:_____

_____

PRIOR HISTORY OF BACK OR NECK PAIN? YES / NO. IF YES, WHERE AND DESCRIBE:

_____

_____

_____

NAME OF DOCTOR OR PERSON WHO REFERRED YOU?_____

NAME & TELEPHONE # OF YOUR FAMILY DOCTOR?_____

WHAT IS THE REASON FOR TODAY'S VISIT?_____

IS ILLNESS RELATED TO AN ACCIDENT? YES / NO WORK?_____ AUTO?_____ OTHER_____

DATE OF ONSET OF ILLNESS OR INJURY?_____

PLEASE EXPLAIN ACCIDENT AND GIVE BRIEF HISTORY OF ILLNESS._____

_____

NAMES & TELEPHONE # OF DOCTORS WHO HAVE TREATED YOU FOR THIS ILLNESS OR INJURY.

_____

_____

ALLERGIES:

ARE YOU ALLERGIC TO ANY MEDICATIONS? (PLEASE CIRCLE) YES / NO.

IF YES, PLEASE LIST THE MEDICATIONS YOU ARE ALLERGIC TO AND DESCRIBE THE TYPE OF ALLERGIC REACTION TO EACH.

_____

_____

_____

_____

MEDICATIONS:

PLEASE LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING, PRESCRIBED AND OVER THE COUNTER, ALONG WITH DOSAGE (HOW MANY MILLIGRAMS) AND FREQUENCIES (HOW OFTEN).

MEDICINE	DOSAGE	FREQUENCIES

_____

_____

_____

_____

_____

_____

_____

_____

OPERATIONS:

HAVE YOU EVER HAD SURGERY BEFORE? (PLEASE CIRCLE) YES / NO.
IF YES, WHAT TYPE OF OPERATION WAS PERFORMED AND WHEN?

_____

_____

_____

_____

_____

_____

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your treatment, general medical condition, diagnosis, healthcare operations and / or your payments:

   _____
   _____

2. Please list the family members or significant others, if any whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   _____
   _____

3. Please indicate if you want all correspondence from our office sent in a sealed envelope marked “CONFIDENTIAL”:

   ☐YES_____ ☐NO_____

4. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if **other than your home phone number:**

   (___)_____

5. Can confidential messages be left on your telephone answering machine?

   ☐YES_____ ☐NO_____

MEDICAL RECORDS FAX TRANSMISSION AUTHORIZATION

I, _____, understand that you will be transmitting my medical records via fax transmission and authorize you to do so. If another party in error receives them, I absolve **Dani S. Bidros, M.D.,** of any and all liability relating to such submission of said records.

PATIENT NAME _____
(guardian if under 18 years)

_____ _____
PATIENT / GUARDIAN SIGNATURE DATE

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POLICY REGARDING NARCOTICS AND MEDICATIONS

1. Allow at least 48 hours for our office to call back in response to your request for a prescription/refill for medication.
2. We **do not** prescribe narcotics as a general pain treatment. Our physician is a surgeon who recommends surgery or pain management techniques to treat pain.
3. We **do** prescribe post-operative pain management medications in the form of narcotics and nonsteroidals, and these will be provided for patients for a determined period of time and no later than three (3) months after surgery.
4. We **do not** prescribe non-narcotic, sedating medications such as benzodiazepines or other types of pain relievers. These need to be filled by your primary care physicians.
5. Patients that are receiving narcotic medications from our physician in the post-operative period must contact the office within a 72 hour timeframe for prescription refills.
6. Prescriptions will **not** be refilled in a 24 hour time slot.
7. Prescriptions can be either mailed or picked up at the office. If you or a family member pick up a prescription at the office, identification in the form of a valid driver's license is required before a prescription will be dispensed. **There will be no exceptions to this rule.**

Prescriptions will ONLY be called in on Tuesdays and Thursday.

Signature of Patient: _____ Date: _____

Please provide us with the following information:

Pharmacy Name: _____

Address: _____

_____

Phone: _____

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FINANCIAL AGREEMENT

I hereby assign and authorize payment of insurance benefits otherwise payable to me, directly to Dani S. Bidros, M.D. for office or hospital services, which are not paid by me at the time of service.

I understand that I am ultimately responsible for payment of any and all charges for medical care received from Dr. Bidros and if this assignment of claim is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full.

In the matter of balances remaining unpaid, it is the policy of our office to refer such outstanding debts to either a collection agency or attorney for further action. Accounts referred to either a collection agency or attorneys are subject to a late fee of 35% of the unpaid amount. In the event my account is referred to any outside source for collections, I agree to pay the late charges as stated above.

Date: _____

DOB: _____

Print Name of Insured/Patient:_____

Signature of Insured/Patient: _____

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3. We **DO** prescribe POST-OPERATIVE pain management medication in the form of narcotics and non-steroidal, and these will be provided for patients for a determined period of time and no later than three (3) months after surgery.
4. We **DO NOT** prescribe non-narcotic, sedating medications such as benzodiazepines or other types of pain relievers. These need to be filled by your primary care physician.
5. Patients that are receiving narcotic medications from our Physician in the postoperative period must contact the office within 72 hours for refills.
6. Prescriptions will **NOT** be refilled within a 24 hour time slot.
7. Prescriptions can either be called in, if we are able to, or picked up in the office.

POLICY REGARDING RADIOLOGIC FILMS/DISKS:

If our Physician orders x-rays, CAT scans or an MRI, **YOU** must be seen again in consultation to review those studies. Rare exceptions can be made on a case by case basis AND must be approved by our Physician. We cannot mail your films/disk back to you. You MUST pick them up in the office.

POLICY REGARDING FORMS FILLED OUT BY OUR PHYSICIAN:

(MEDICAL LEAVE AND/OR ALL DISABILITY FORMS)

A fee of $30.00 will be assessed to the patient for any forms which needs to be completed.

If you have any questions or concerns regarding these policies or procedures, please feel free to contact me by telephone or by the email listed below.

Thank you,
Dr. Dani Bidros

(281) 529-6626
info@westhoustonbrainandspine.com

Your signature indicates that you have read the terms stated above and received a copy.

Patient Signature: _____

Date: _____

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MEDICAL RECORDS RELEASE/AUTHORIZATION

I hereby authorize Dani S. Bidros, M.D. to release and/or receive any and all information:

1. Requested by my insurance company or worker's compensation carrier;
2. To any hospital or physician I may be referred to by Dr. Bidros;
3. From any hospital or physician who has previously rendered me treatment

Date: _____

DOB: _____

Print Name of Insured/Patient:_____

Signature of Insured/Patient: _____

Email Save Print