NEW PATIENT INTAKE FORM

Initial Appointment Date: _____

PATIENT INFORMATION		
Last Name:	First Name:	Middle:
Date of Birth:	Sex:	
Marital Status: ☐Single ☐Married ☐Domestic Partner ☐Divorced ☐Widowed ☐Other: _____		
Phone: (please check preferred #): ☐Home:	☐Mobile:	☐Work:
Address:		
City, State: Zip Code:		
Email:		
Would you like to receive email reminders prior to appointments? ☐Yes ☐No		
Race/Ethnicity: ☐American Indian ☐Asian ☐Black ☐Latino/Hispanic ☐Pacific Islander ☐White ☐Other: _____		
Employment Status (check all that apply): ☐Full-time ☐Part-time ☐Retired ☐Unemployed ☐Self-Employed ☐Student		
Occupation/Employer:		
Emergency Contact:	Relationship:	Phone:
Referred by:		

INSURANCE (Primary)		
Insurance Company:	Policy Holder Name:	
Relationship to Patient:		
Policy # / ID #:	Group #:	
Insurance Company Address:		Phone:

INSURANCE (Secondary)		
Insurance Company:	Policy Holder Name:	
Relationship to Patient:		
Policy # / ID #:	Group #:	
Insurance Company Address:		Phone:

CHIEF COMPLAINT (*Continue on the back side of page as needed*.) What is the reason for today's visit?
Was this related to an accident? Yes/No ☐Work ☐Auto ☐Other Date of accident:
Please describe the nature and timing of onset:
What makes it better? ☐Activity ☐Rest ☐Stretching ☐Heat ☐Cold ☐Massage ☐Other:
What makes it worse? ☐Activity ☐Rest ☐Stretching ☐Heat ☐Cold ☐Massage ☐Other:
Have you received any treatment for this health issue? ☐Yes ☐No Please describe:
Primary Care Physician: Phone: Address:

ALLERGIES	
Are you allergic to any medications? ☐Yes ☐No	
MEDICATION ALLERGY	**REACTION**

MEDICATIONS /SUPPLEMENTS (*list any you are currently taking*):	**Dosage:**	**Frequency:**

SOCIAL HISTORY (*Pleases check any that apply to you, past or present*): Caffeine use: ☐Yes ☐No How much per day:
Do you smoke: ☐Former smoker ☐Never smoked ☐Current smoker ☐Current someday How often/last smoked:
Do you consume alcohol: ☐Never ☐Moderate ☐Occasionally ☐Heavy
History of abuse of illicit drugs: ☐Yes ☐No Type:
Right or Left handed:

MAJOR HOSPITALIZATIONS:		
Injury, Illness or Surgery	**Hospital**	**Date**

PAST OR PRESENT HEALTH HISTORY:	
Arthritis problems?	If yes, please describe:
Joint problems?	If yes, please describe:
Lung problems?	If yes, please describe:
Bleeding disorder?	If yes, please describe:
Blurred or Double vision?	If yes, please describe:
Cancer?	If yes, please describe:
Changes in speech?	If yes, please describe:
Diabetes?	If yes, please describe:
Difficulty hearing?	If yes, please describe:
Fainting spells?	If yes, please describe:
Migraines?	If yes, please describe:
Headaches?	If yes, please describe:
Head injury?	If yes, please describe:
Heart disease?	If yes, please describe:
Hepatitis?	If yes, please describe:
High blood pressure?	If yes, please describe:
Abdominal problems or pain?	If yes, please describe:
Bladder problems?	If yes, please describe:
Bowel problems?	If yes, please describe:
Numbness or tingling?	If yes, please describe:
Peripheral vascular disease?	If yes, please describe:
Psychiatric illness?	If yes, please describe:
Serious childhood illness?	If yes, please describe:
Seizures?	If yes, please describe:
Serious infection?	If yes, please describe:
Stroke?	If yes, please describe:
Tuberculosis?	If yes, please describe:
Ulcers?	If yes, please describe:
Weakness?	If yes, please describe:
Surgical or Anesthetic complications?	If yes, please describe:
Remembering or Concentrating?	If yes, please describe:
Back or neck pain?	If yes, please describe:

WEST HOUSTON
BRAIN SPINE

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 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 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 or identification card is required before a prescription will be dispensed. **There will be no exceptions to this rule.**

Signature of Patient: _____ Date: _____

Please provide us with the following information:

Pharmacy: _____
Address: _____
_____
Phone: _____

Dani S. Bidros, MD 2222 Greenhouse Rd, #1100A, Houston, TX 77084 PH: 281-529-6626 Fax: 832-288-5967

WEST HOUSTON
BRAIN SPINE

Financial Agreement

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

I understand that I am ultimately responsible for payment of any and all charges for medical care received from Dani S. Bidros, MD and if his 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: _____

Patient Name: _____

Signature of Patient: _____

Medical Records Release/Authorization

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

1. Request by my insurance company or worker's compensation carrier.

2. To any hospital or physician, I may be referred to by Dani S. Bidros, MD.

3. From any hospital or physician who has previously rendered me treatment.

Date: _____

DOB: _____

Patient Name: _____

Signature of Patient: _____

Dani S. Bidros, MD 2222 Greenhouse Rd, #1100A, Houston, TX 77084 PH: 281-529-6626 Fax: 832-288-5967

WEST HOUSTON
BRAIN SPINE

Release of Medical Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse_____
☐ Child(ren)_____
☐ Other_____

☐ Information is not to be released to anyone.

Messages

Please call: ☐ Home ☐ Work ☐ Cell

If unable to reach me:

☐ Leave a detailed message.
☐ Leave a message asking me to return your call.

Medical Records Fax Transmission Authorization

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

Patient Name: _____

Patient Signature: _____ Date: _____

Dani S. Bidros, MD 2222 Greenhouse Rd, #1100A, Houston, TX 77084 PH: 281-529-6626 Fax: 832-288-5967

WEST HOUSTON
BRAIN SPINE

Dear New Patient:

Welcome to the neurosurgical practice of West Houston Brain and Spine. Dr. Bidros is a neurosurgeon specialized in the diagnosis and surgery of the brain, spine, and peripheral nerves. We promise you expert and compassionate care. It is a privilege to serve you.

On your **first visit** it is essential for you to bring with you **ALL** available reports, x-rays and imaging (MRI or CT) related to your condition. A radiologist's report is NOT a substitute for the CD's themselves. You are **RESPONSIBLE** for bringing the CD and report with you to your appointment.

You will be **required** to have your personal ID, insurance card and copay/deductible available. We accept all major credit cards, cash or check. We will file insurance claims on your behalf.

If you are **unable** to attend your scheduled appointment, please advise our office as soon as possible and we will be happy to reschedule your appointment. We try to be on time for our scheduled appointments, but emergency consultations and/or surgeries sometimes disrupt our schedule. For your convenience, we will notify you as soon as possible if there is a change in our schedule.

This information is essential for your evaluation.

Thank you,
West Houston Brain and Spine

Dani S. Bidros, MD 2222 Greenhouse Rd, #1100A, Houston, TX 77084 PH: 281-529-6626 Fax: 832-288-5967

WEST HOUSTON
BRAIN SPINE

Appointment Cancellation Policy

We would like to welcome you to West Houston Brain and Spine, PA. We highly believe in personalized attention during your visit. We do value your time and maximize patient care, once your appointment is scheduled with the doctor, that time will be reserved for you. When you make an appointment, please be sure that you will be able to keep it. Our office will contact you prior to your appointment to confirm it. Please make a note of your appointment in a place where you will be easily reminded, if you cannot make an appointment as scheduled, please notify the office **24 hours in advance**. There will be a charge of **$50.00** for a no show or cancellation with less than 24 hours' notice.

Date: _____

Patient Name: _____

Signature of Patient: _____

Dani S. Bidros, MD 2222 Greenhouse Rd, #1100A, Houston, TX 77084 PH: 281-529-6626 Fax: 832-288-5967