10496 Montgomery Road, Suite 201, Cincinnati, OH 45242
Phone (513) 230-2000 Fax (513) 596-1331

3533 Southern Blvd., Suite 3000, Kettering, OH 45429
Phone (937) 299-8242 Fax (937) 299-8245
www.cincinnatineurosurgery.com

Dear Patient:

We welcome you to our practice. We will be seeing you in consultation to assess if we will be involved in your treatment.

Enclosed you will find copies of various forms to be filled out before your scheduled appointment. Please complete, sign and date these forms prior to your office visit. Be sure to use ONLY black or blue PEN (not pencil) when filling out these forms and signing them. Bring the completed forms with you to your office visit.

__X__ Bring a list of your medications (or write them down on the enclosed form).
__X__ Bring your Insurance Card(s) and Photo ID card
__X__ Bring your Imaging films (MRI, CT, X-RAYS) This will probably be on a CD (disk) – If you don't already have this CD – contact the facility where it was done – so that you can pick up the disk at some point before your scheduled appointment.

Co-pay and /or deductibles are due at the time of your appointment (cash, check, Mastercard, Visa, Discover or Amex are accepted in this practice).

It is also very important that you check with your insurance company to make sure that we are a part of your insurance network.

Your appointment is on _____ at _____ AM/ PM
_____Arrive 30 minutes prior to your appointment for x-rays. **if you have completed BOTH sections of the portal and it states it is COMPLETE**
_____Arrive 1 hour before your appointment if you are unable to complete your information on the web portal, to allow enough time to fill out additional paperwork.

There will be a $50.00 charge for any cancellations made within 24 hours of your appointment.*

_____CINCINNATI OFFICE (10496 Montgomery Road #201, Cincinnati OH) (on the Bethesda North Campus)
_____KETTERING OFFICE (3533 Southern Blvd., Suite 3000 Kettering, OH)
(Physicians office building connected to Kettering Hospital)

Sincerely Yours,
Advanced Neurosurgery, Inc.
Jonathan Borden, MD

Advanced Neurosurgery
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____ **First** _____ **MI** _____

Sex: ☐ Male ☐ Female Height**:**_____ Weight**:**_____ **Date of Birth:** _____

Referring Physician: _____ **Name of Primary Care Physician:** _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	**Dosage**	**How Often Taken**

ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No. If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS.

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____Yes ____No
If yes, please list type of problems: _____

_____

_____

List any surgeries you have had (including dates):

_____

_____

_____

Have you ever been hospitalized for non-surgical reasons? ___Yes ___ No
If yes, list reasons for hospitalizations _____

_____

CURRENT OR MOST RECENT OCCUPATION: _____

Advanced Neurosurgery, Inc.

Patient Registration

Patient Name_____ ❑Male ❑Female Birthdate_____ Age:_____

Address:_____ City:_____ State_____ Zip_____

Alternate Address for Mailing(optional):_____

Home Phone:_____ Work Phone:_____ Social Security#_____-_____-_____

Cell Phone:_____ E-Mail:_____

Employer/School:_____ Occupation:_____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

May we leave a message at your home with other residents? ❑Yes ❑No On your answering machine/voicemail? ❑Yes ❑No

Who may we contact about your medical concerns:_____

Is this contact for emergency purposes only? ❑Yes ❑No, you can talk to this person whenever needed.

Relationship of this person to you ❑Spouse ❑Other_____ Phone:_____

Responsible party for insurance and bills ❑Patient ❑Spouse ❑Parents ❑Other _____

Primary Insurance Company _____

Subscribers Name_____ Date of Birth_____ Soc.Sec#_____

Secondary Insurance Company_____

Subscribers Name_____ Date of Birth _____ Soc.Sec#_____

Copays and Copies of Insurance Cards are Required at time of Care!

Identification of other physicians/health care entities involved with my medical care whom I authorize ongoing release of information for continuity of care, this may be a family physician, pain physician, surgeon or specialist:

Referring Physician (First & Last Name)_____ Phone_____

Doctor's Address_____ Fax:_____

Family Physician (First & Last Name)_____ Phone_____

Doctor's Address_____ Fax_____

Date:_____

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Jamal Taha, MD
Jonathan Borden MD

Authorization for Release and Examination of Medical Records (PHI)

Patient's Name:_____ **Date of Birth**_____

TO: _____

_____

_____

I hereby authorize and request that you release the records and information to the entity identified below:

I hereby authorize, _____ to furnish a complete copy of the medical record, medical information, also known as PHI and related data for the above identified person from:

■ All records
☐ Records from _____ (date) to _____(date).
I am aware that there may be information in the medical record that relates to substance abuse, mental illness or HIV/AIDS that is of a highly confidential level.

I am aware that I can revoke this release at any time prior to the records being released to the above entity and that this release is valid until _____(date).

I am also aware that I may be charged a fee to process this medical record request of $3.07/page for first 10 pages and an additional fee of $0.64 per page for pages 11-50, and $0.26 per page for pages 51 and higher.

There is no charge from our office to send notes to the referring doctor and/or family doctor.

X_____ _____
Signature of Patient/Legal Guardian **Date**

X_____ _____
Witness Signature **Date**