

### 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 <u>sure to</u> 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.

# <u>Co-pay and /or deductibles are due at the time of your appointment (cash, check,</u> 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: Nam	e 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

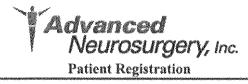
#### SURGERIES AND HOSPITALIZATIONS.

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-surgic	al reasons? Yes	No	
If yes, list reasons for hospitalizations	If yes, list reasons for hospitalizations			

# CURRENT OR MOST RECENT OCCUPATION: \_\_\_\_\_



Patient Name		Birthdate	Age:
Address:	City:	State	
Alternate Address for Mailing(optional):			
Home Phone: Wo	rk Phone:	Social Security#	
Cell Phone: E-1	Mail:		,
Employer/School:	Occupation:		
Marital Status: Single CMarried Divorced C	JWidowed	2010/07/10/07/10/07/10/10/10/10/10/10/10/10/10/10/10/10/10/	
May we leave a message at your home with other	residents? IYes INo On you	r answering machine/voicem	nail? 🛛 Yes 🗖 No
Who may we contact about your medical concern	\$:		а промати с асторитација и асторија пријада рекорато у округаја Прија
Is this contact for emergency purposes only?	es 🛛 No, you can talk to this pers	son whenever needed.	
Relationship of this person to you Spouse Oth	her	Phone:	
Responsible party for insurance and bills DPatien	nt 🛛 Spouse 🖓 Parents 🖾 Other		
Primary Insurance Company			
Subscribers Name	Date of Bir	thSoc.Se	c#
Secondary Insurance Company			
Subscribers Name	Date of Bir	th Soc.Sec	H.
Copays and Copi	es of Insurance Cards are Requ	ired at time of Care!	
Identification of other physicians/health care entit for continuity of care, this may be a family physic			g release of information

Referring Physician (First & Last Name)	Phon	e
Doctor's Address	Fax	7.C. 2
Family Physician (First & Last Name)	Phon	e
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	я Ферерарияние до на полно и полн Полно и полно и	Date	of Birth	westensteinistenstenstellen anter statistenstellen som
то:		90000 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	550 ga	

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

 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.\*\*\*

Signature of Patient/Legal Guardian

Date

X Witness Signature

X

Date