It is the responsibility of the patient to make sure all imaging studies (MRI, CT, X-Ray, etc.) CDs are physically available for your appointment.

Please Note - the facilities and physician's office will only send reports, not the **CDs**. **You will need to bring the CDs with you. Otherwise, your appointment may need to be rescheduled.**

- **MEDICAL RECORDS**

  Please call your referring physician, primary care and all other physicians involved in your care to request that copies of all medical records related to the condition for which you are being referred be forwarded to our practice prior to your appointment. **Fax to 302-292-8118**.

- **REFERRALS AND AUTHORIZATIONS**

  It is your responsibility to obtain from your referring/primary care physician all necessary referrals/authorizations that are required by your medical insurance plan.

  Please note: If applicable, additional referrals/authorizations are required from Workers' Compensation Insurance and Auto Liability Insurance plans.

- **MEDICAL HISTORY FORM**

- **PATIENT INFORMATION FORM**

- **MEDICATION LIST**

  Please list all prescribed medications, all over-the-counter medications, and all vitamins and herbal supplements.

- **PHOTO ID IS REQUIRED AT TIME OF VISIT**

- **PRIMARY AND SECONDARY MEDICAL INSURANCE CARDS and, if applicable, ALL INFORMATION RELATED TO WORKERS' COMPENSATION, AUTO OR PERSONAL LIABILITY INSURANCE**

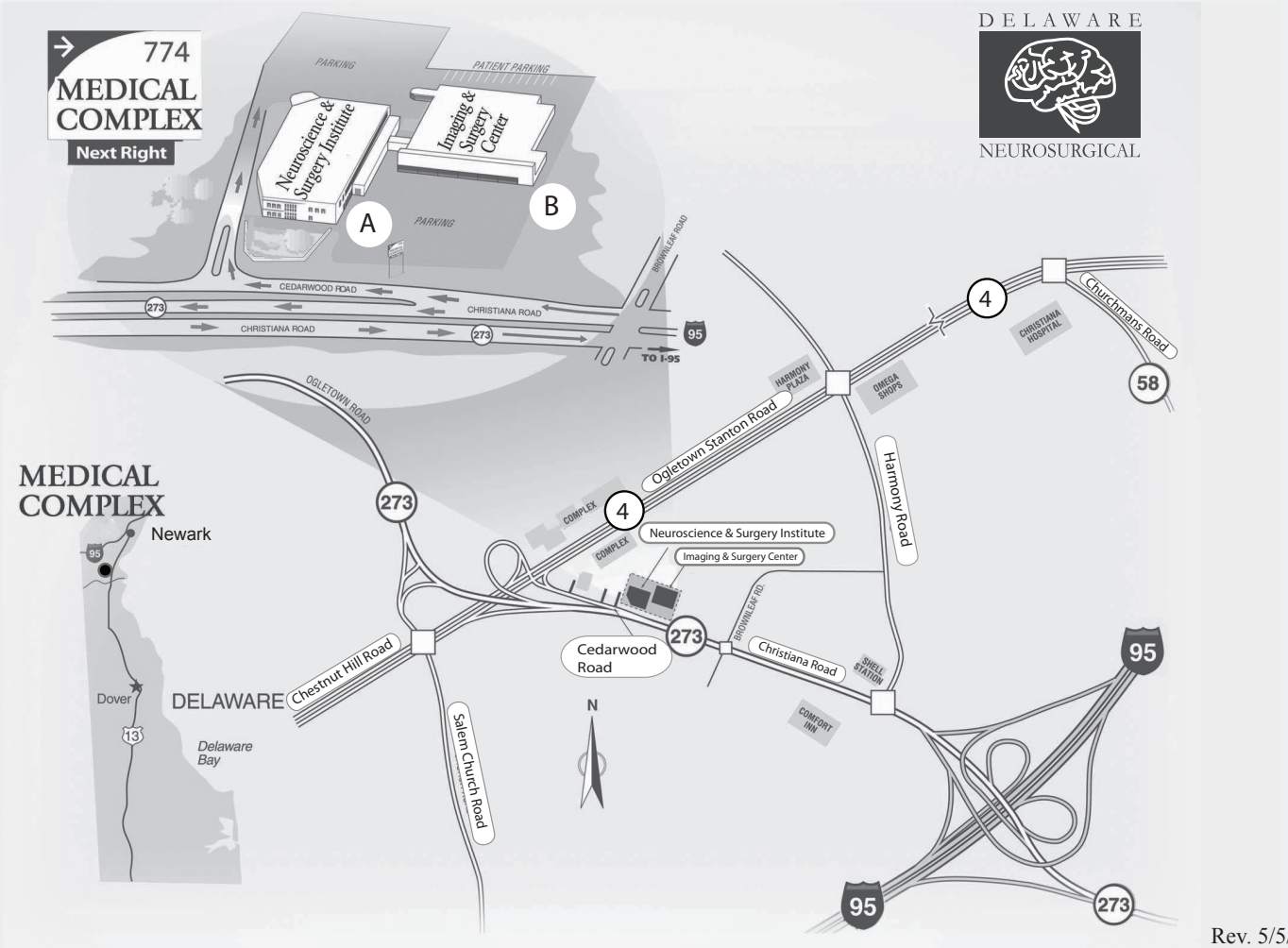
- **CO-PAYS ARE DUE AT TIME OF SERVICE**

If you have any questions or concerns prior to your visit, please feel free to call us at the phone number listed on the enclosed letter. Our staff members will be happy to assist you. Thank you for selecting our practice for your medical care.

Directions to Newark Office

(Directions to Elkton Office on Reverse)

NEUROSCIENCE & SURGERY INSTITUTE
OF DELAWARE



Rev. 5/5/11

We are conveniently located just minutes from Christiana Hospital, and the only level 1 trauma center in the state.

From I-95 North & South:
Take I-95 to Exit 3B (Route 273 West toward Newark). Stay in the right lane. Go through 2 lights and get off at the first exit marked Cedarwood Road. Stay to the far right and make the first hard right into the Medical Complex. Proceed to the parking lot, building A.

From Route 4 West:
From Route 4 West, go past Christiana Hospital to the traffic light at Harmony Road. Make a left onto Harmony Road and follow to the traffic light at Route 273. Make a right onto route 273. Stay in the right lane. Go through 1 light and get off at the first exit marked Cedarwood Road. Stay to the far right and make the first hard right into the Medical Complex. Proceed to the parking lot, building A.

From Route 4 East:
From Route 4 East, make a right at the traffic light on Harmony Road and follow to the traffic light at Route 273. Make a right onto 273. Stay in the right lane, go through 1 light and get off at the exit marked Cedarwood Road. Stay to the far right and make the first hard right into the Medical Complex. Proceed to the parking lot, building A.

From Route 273 East:
273 East is on the opposite side of the median strip from the Medical Complex. You must pass the Neuroscience and Surgery Institute of Delaware and follow 273 to the traffic light at the Shell Station on Harmony Road. Get in the left lane. You will get a green arrow/signal allowing you to make a legal U-turn to head back onto 273 heading west.

Once you make that U-turn, stay in the right lane. Get off at the first exit marked Cedarwood Road. Stay to the far right and make the first hard right into the Medical Complex. Proceed to the parking lot, building A.

From Route 273 West:
From Route 273 West, pass the Shell Station at Harmony Road, staying in the right lane. Go through 2 lights and get off at the first exit marked Cedarwood Road. Stay to the far right and make the first hard right into the Medical Complex. Proceed to the parking lot, building A.

From Southern Delaware:
Take Route 1 to Exit 162 (the Exit for Route 273). At the bottom of the exit ramp, turn left at the light. Continue 2.2 miles on Route 273. Stay in the far right lane and get off at the exit marked Cedarwood Road. Make the first hard right into the Medical Complex. Proceed to the parking lot, building A.

Delaware Neurosurgical Group, P.A.

774 Christiana Road, Suite 202 • Newark, Delaware 19713
Tel: (302) 366-7671 • Fax: (302) 366-7655

Directions to Elkton Office

111 West High Street, Suite 211
Medical Professional Building
Elkton, MD 21921

Take I-95 South to Exit #1A (Middletown Exit, Route 896). After coming off the ramp, stay in the right lane. At the first traffic light, make a right onto Old Baltimore Pike. Follow this for 7-8 miles into the town of Elkton. (Be sure not to exceed the speed limit). Once in Elkton, go through one traffic light until you reach a stop sign at a four-way intersection. Turn right at this stop sign, and when you reach a second stop sign, turn left. At this point, you will see Union Hospital directly in front of you. Drive through one traffic light, and the medical building will be on your right. Turn right before the crosswalk bridge, and park in the parking garage.

(Directions to Newark Office on Reverse)

Delaware Neurosurgical Group, PA
Patient Information Form

Required Fields

*Name _____ S.S. _____

*Address _____ E-mail _____

*City _____ *State _____ *Zip _____ *☐ Married ☐ Separated ☐ Single ☐ Minor

*Home Tele. # _____ Cell Tele. # _____ Pharmacy _____

*Sex ☐ M ☐ F *Age ____ *Birth date _____ Pharmacy Tele. # _____

Patient Employer/School _____ *Occupation _____

Employer/School Address _____ *Employer/School Tele. # _____

*Referring Physician _____ Referring Physician Tele. # _____

*Family Physician _____ Family Physician Tele. # _____

*Emergency Contact _____ *Relationship _____ *Tele. # _____

*PRIMARY INSURANCE

Insurance Co. _____ Policy # _____ Group # _____

Insured's Name (if different from patient) _____ Insured's Relationship to Patient _____

Insured's Tele. # _____ DOB _____ SSN# _____ Ins. Effective Date _____

Insured's Address _____ City _____ State _____ Zip _____

Insured's Employer _____ Employer's Tele. # _____

*ADDITIONAL INSURANCE

Insurance Co. _____ Policy # _____ Group # _____

Insured's Name (if different from patient) _____ Insured's Relationship to Patient _____

Insured's Tele. # _____ DOB _____ SSN# _____ Ins. Effective Date _____

Insured's Address _____ City _____ State _____ Zip _____

Insured's Employer _____ Employer's Tele. # _____

*ACCIDENT INSURANCE

☐ Workers' Compensation ☐ Auto Accident Injury Date _____ Claim # _____

Insurance Company _____ Contact Name _____ Tele. # _____

Insurance Address _____ City _____ State _____ Zip _____

Attorney Name _____ Tele. # _____

Address _____ City _____ State _____ Zip _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Delaware Neurosurgical Group, PA (DNG), its employees, medical providers and authorized agents to release all information, including any or all of my medical records that may be required for payment of my charges by my insurance company, HMO, Medicare or other third party payer. I authorize that payment be made directly to DNG or its authorized agents. I understand that I am financially responsible to pay for any charges not covered by other sources.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE.

*Patient/Responsible Party Signature _____ *Date _____

Electronically Signed (if applicable)

Delaware Neurosurgical Group, PA

The Federal Government Now Requires Us to Obtain the Following Information

Name: _____
Please Print

Preferred Language: _____

Race:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Asian and Black/African American
- ❑ Asian and White
- ❑ Black/African American
- ❑ White and Black/African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Undetermined

Ethnicity: ❑ Hispanic or Latino ❑ Non Hispanic or Latino ❑ Undetermined

Thank you.
Delaware Neurosurgical Group

MEDICATION LIST

Patient Name: _____

DOB: _____

List all medications including prescriptions, non-prescriptions, vitamins, and herbal supplements.

Medication	Prescribing Physician	Dosage	Frequency

Medical History

Name: _____ Date: _____

Date of Birth: _____

Main Complaint (Reason for visit): _____

_____

_____

Date Symptoms Started: _____

How did this problem begin? _____

_____

What makes it better? _____

Worse? _____

Have you had a similar condition? _____

What treatment have you received and by whom? _____

_____

Is this visit for a second opinion only? ❑ Yes ❑ No (Provide opinion or advice only)

If so, who referred you? _____ When? _____

Diagnostic Testing (MRI, CT scan, EMG, X-Ray, Bone Scan, etc.)

Test Date Facility

_____

_____

_____

_____

Accidents: (Car accidents, work accidents, etc.)

Date: Brief Description:

_____

_____

_____

Past Medical History (Illness you have had)

❑ Heart Disease Cardiologist Name: _____ Phone (_____) _____

❑ Diabetes ❑ Migraine Headaches ❑ Asthma ❑ Aids

❑ High Blood Pressure ❑ Seizures When? _____ ❑ Bleeding Problems ❑ Hepatitis

❑ Cancer Type: _____ ❑ Kidney Problems ❑ Thyroid

Other Illnesses/Hospitalizations:

1._____
2._____
3._____
4._____
5._____

Operations (include dates):

1._____
2._____
3._____
4._____
5._____

Medications (include dosage):

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Medication Allergies: ❑ Yes, List ❑ No

1._____
2._____
3._____
4._____

Allergic to **adhesive tape**? ❑ Yes ❑ No

Allergic to **latex**? ❑ Yes ❑ No

***** Do you need more room here?**

Family History

Do any blood relatives have any of the following health problems? Who?

❑ Brain aneurysm _____ ❑ Diabetes _____ ❑ Migraine Headaches _____
❑ Asthma _____ ❑ Heart Disease _____ ❑ Neurofibromatosis _____
❑ Cancer _____ ❑ Hypertension _____ ❑ Polycystic Kidney Disease _____
Type _____ ❑ Stroke _____ ❑ Bleeding Disorder _____
❑ Spinal Problems _____
Other _____

Personal History

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated
Do you smoke? ❑ Yes ❑ No Quantity _____/Day _____ Years
Do you use alcohol? ❑ Yes ❑ No Quantity _____/Day _____ Years
Have you abused illegal / prescription drugs? ❑ Yes ❑ No Drug _____ When? _____
Are you pregnant? ❑ Yes ❑ No Is it possible you could be pregnant? ❑ Yes ❑ No
Height _____ Weight _____ Hand Preference ❑ Right ❑ Left

Have you experienced any of the following in the past year?

Frequent or severe headaches	❑ Yes ❑ No	Bloody cough	❑ Yes ❑ No	Joint pain	❑ Yes ❑ No
Fainting or unconscious spells	❑ Yes ❑ No	Fever	❑ Yes ❑ No	Fatigue	❑ Yes ❑ No
Dizziness	❑ Yes ❑ No	Swelling of hands,		Brittleness of nails	❑ Yes ❑ No
Blurred vision	❑ Yes ❑ No	feet & ankles	❑ Yes ❑ No	Dryness of skin	❑ Yes ❑ No
Change in vision	❑ Yes ❑ No	Abdominal pain	❑ Yes ❑ No	Easy bruising	❑ Yes ❑ No
Ringing in your ears	❑ Yes ❑ No	Nausea or vomiting	❑ Yes ❑ No	Inability to stand heat	❑ Yes ❑ No
Difficulty hearing	❑ Yes ❑ No	Vomited blood	❑ Yes ❑ No	Inability to stand cold	❑ Yes ❑ No
Strange persistent odors	❑ Yes ❑ No	Diarrhea	❑ Yes ❑ No	Excessive thirst	❑ Yes ❑ No
Difficulty swallowing	❑ Yes ❑ No	Bloody stools	❑ Yes ❑ No	Excessive urination	❑ Yes ❑ No
Sinus trouble	❑ Yes ❑ No	Rectal pain	❑ Yes ❑ No	Skin rash	❑ Yes ❑ No
Chest pain	❑ Yes ❑ No	Weight gain	❑ Yes ❑ No	Hallucinations	❑ Yes ❑ No
Shortness of breath	❑ Yes ❑ No	Weight loss	❑ Yes ❑ No	Numbness/Tingling	❑ Yes ❑ No
Palpitations	❑ Yes ❑ No	Pain on urinating	❑ Yes ❑ No	Menstrual irregularity	❑ Yes ❑ No
Wheezing	❑ Yes ❑ No	Difficulty starting urination	❑ Yes ❑ No		
How many pillows do you sleep on? _____		Getting up at night to urinate	❑ Yes ❑ No		
Night sweats	❑ Yes ❑ No	How many times? _____			
Frequent cough	❑ Yes ❑ No	Loss of bladder control	❑ Yes ❑ No		

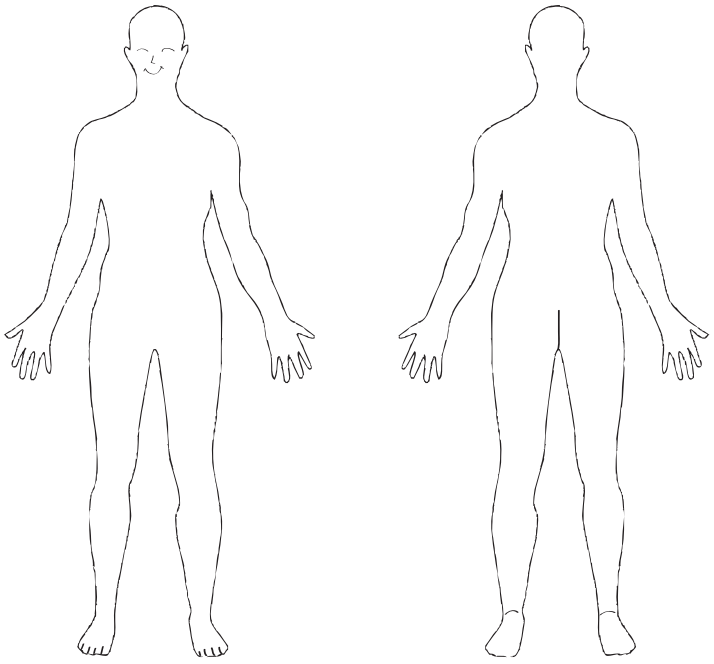
The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my physician or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

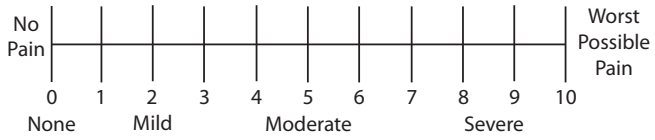
Date: _____ Patient's Signature: _____

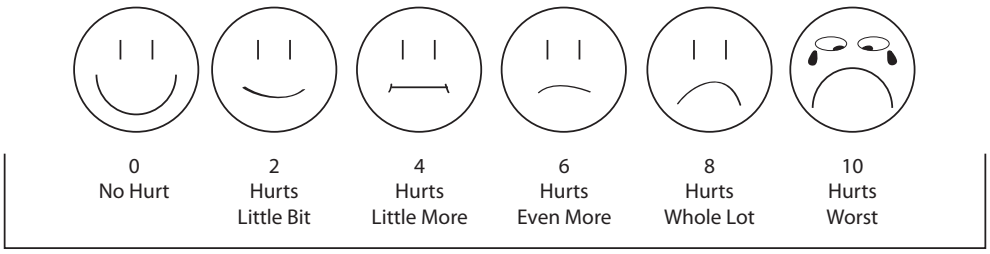
Electronically Signed (if applicable)

Physician's Signature: _____

Physical Exam







Please describe below:

AUTO ACCIDENT AND PERSONAL INJURY

Please Print

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Insurance Company: _____

Address: _____

Claim Number: _____ Adjuster Name: _____

Phone Number: _____ Date of Accident: _____

Was the injury reported to the local authorities? ___ NO ___ YES

Briefly describe the accident and injuries: _____

_____

If you have an attorney, please provide name, address and telephone number: (This is for our chart information only; we will not bill your attorney for services rendered.)

_____

_____

I understand that my Delaware Neurosurgical Group, P.A. providers are entitled to be paid for services rendered. In the event of a legal settlement, I agree that any "paid" health insurance claim will subrogate back to my health insurance provider. All balances due to Delaware Neurosurgical Group, P.A. for services performed will be paid by my legal representative, regardless of the amount paid by my health insurance provider or any adjustments made to payments based on contractual agreements with my health insurance provider.

In the event my claims are denied by the above listed insurance carrier, I understand my personal health insurance will be billed. Therefore, for my protection, I will obtain the necessary referrals if applicable. I understand that I am responsible for any payment of all services rendered should my claims be denied.

SIGNATURE: _____ DATE: _____

Electronically Signed (if applicable)

WORKMAN'S COMPENSATION

Please Print

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Employer: _____

Address: _____

Phone Number: _____ Supervisor: _____

Worker's Compensation Insurance Carrier: _____

Address: _____

Claim Number: _____ Adjuster Name: _____

Phone Number: _____ Date of Accident: _____

Was this injury reported? ___ NO ___ YES If yes, to whom: _____

Briefly describe the accident and injuries: _____

_____

If you have an attorney, please provide name, address and telephone number: (This is for our chart information only; we will not bill your attorney for services rendered.)

_____

_____

I understand that Delaware Neurosurgical Group, P.A., as a certified Workman's Compensation provider for the State of Delaware, is entitled to be paid for services rendered at the full published Delaware Workman's Compensation fee schedule in effect on the date(s) of service. In the event of a legal settlement, I agree that any "paid" health insurance claim will subrogate back to my health insurance provider. All balances due to Delaware Neurosurgical Group, P.A. for services performed will be billed to and paid by my legal representative in accordance with the applicable Workman's Compensation fee schedule, regardless of the amount paid by my health insurance provider or any adjustments made to payments based on contractual agreements with my health insurance provider.

In the event my claims are denied by the above listed insurance carrier, I understand my personal health insurance will be billed. Therefore, for my protection, I will obtain the necessary referrals if applicable. I understand that I am responsible for any payment of all services rendered should my claims be denied.

SIGNATURE: _____ DATE: _____

Electronically Signed (if applicable)

DELAWARE NEUROSURGICAL GROUP, P.A.

774 CHRISTIANA ROAD
SUITE 202
NEWARK, DE 19713
•PHONE: (302) 366-7671 •FAX: (302) 366-7549

I have read and understand the Notice of Privacy Practices of Delaware Neurosurgical Group, P.A. and its physicians.

_____ _____

Signature Date

Electronically Signed (if Applicable)

Other than myself, the following are persons I authorize Delaware Neurosurgical Group to talk to regarding my medical information:

Relationship to Patient	**Name**
____ Spouse	_____
____ Significant Other	_____
____ Child	_____
____ Parent	_____
____ Guardian	_____
____ Sibling	_____
_____	_____
_____	_____

If we need to contact you, do we have your permission to leave a message on your voicemail or with a person who answers your phone, whether at home or work? Please check below:

At home YES _____ NO _____

At work YES _____ NO _____

Print name _____

Signature _____ Date _____

Electronically Signed (if applicable)

Notice of Privacy Practices Acknowledgment

Delaware Neurosurgical Group, P.A.

302-366-7671

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Electronically Signed (if applicable)

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

Staff- Scan under:

- *Category "Patient registration"*
- *Code "HIPAA"*

Name: _____ Date: _____

D.O.B.: _____

1. Do you currently take NSAIDS? Yes or No (Circle or Select)
   (i.e. Aspirin, Ibuprofen, Advil, Aleve)

2. Have you tried Physical Therapy? Yes or No (Circle or Select)

   Start Date: _____ End Date: _____

   If yes, how many weeks/sessions? _____

3. Have you had injections? Yes or No (Circle or Select)

   a. If yes, how many and by whom? _____

4. What is your pain level out of 10? (10 being the worst)

   At worst _____, At rest _____ **(i.e., sitting, laying down, sleeping)**

5. Does the pain interfere with activities of daily living? Yes or No (Circle or Select)
   (i.e. walking, bending, weight bearing, or going up/down stairs)

6. Please circle one: current smoker former smoker never smoked (Circle or Select)

7. How many times in the past **YEAR** have you had **FIVE (males)** or
   FOUR (females and adults over 65) or more drinks in a **day**? _____

8. Any falls in the **past year**? Yes or No (Circle or Select)

   If yes, how many? _____ **Were you injur ed**? Yes or No
   (Circle or Select)

9. Do you use crutches, cane or a walker to ambulate? Yes or No (Circle or Select)

10. Do you need to clutch onto furniture when ambulating for support? Yes or No (Circle or Select)

11. Who is your decision maker if unable to indicate wishes about future life sustaining medical treatment?

Name: _____ Relationship: _____

Contact information: _____

12. Do you have children? Yes or No (Circle or Select)

   If yes, how many? _____