Coastal NeuroSurgery P.A.

RICHARD C. HARTWELL, M.D., Ph.D.
Diplomate American Board of Neurological Surgery

9 Hospital Drive Suite C10
Toms River, New Jersey 08755
Telephone (732) 341-1881
Facsimile (732) 505-4453

www.CoastalNeuroSurgeryNJ.com

PATIENT INFORMATION SHEET Patient #_________

NAME OF PATIENT ____AGE ____________

ADDRESS____
Street City State Zip Code

SOCIAL SECURITY #_____________________ DATE OF BIRTH________________

HOME PHONE (____)______________________ CELL PHONE (____)________________

EMPLOYER ___________________________________ PHONE (____)_________________

EMERGENCY CONTACT__________________________ PHONE (___)________________

REFERRING M.D.________________________ ADDRESS___________________________

REASON FOR YOUR VISIT TODAY:____

DO YOU SMOKE? NO_____ YES____ PACKS PER DAY SMOKED:_________________

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF YES, PLEASE LIST:
____

PLEASE CIRCLE YES OR NO:

ARE YOU ALLERGIC TO SHELLFISH OR IODINE DYE?	YES	NO
ARE YOU ALLERGIC TO LATEX?	YES	NO
DO YOU TAKE ASPIRIN OR VITAMIN E?	YES	NO
DO YOU TAKE ADVIL, MOTRIN, ALEVE OR NAPROSYN?	YES	NO
DO YOU USE ANY ERECTILE DYSFUNCTION (ED) MEDICINES?	YES	NO

LIST ALL MEDICATIONS AND DOSAGE:____
____
____

LIST ALL HOSPITALIZATIONS AND SURGERIES WITH DATES:___________________
____
____

PATIENT ____

DO YOU HAVE A LIVING WILL (ADVANCE DIRECTIVE)? YES______ NO ________

PERSON IN CHARGE:________________________________ PHONE # ________________

CHECK IF YOU HAVE HAD:

- ❑ ANGINA
- ❑ HEART ATTACK
- ❑ HEART MURMUR
- ❑ HYPERTENSION
- ❑ RHEUMATIC FEVER
- ❑ SHORTNESS OF BREATH
- ❑ EASY BRUISING OR BLEEDING
- ❑ CORNEAL TRANSPLANT: WHEN______
- ❑ SEIZURES
- ❑ DIABETES
- ❑ HEPATITIS/AIDS/HIV
- ❑ KIDNEY DISEASE
- ❑ ULCER DISEASE
- ❑ LUNG DISEASE
- ❑ THYROID DISEASE
- ❑ SEX OR GROWTH HORMONES

ETHNICITY: Are you Hispanic or Latino? YES ___ NO ___

RACE:
- ❑ White
- ❑ Black or African American
- ❑ Asian
- ❑ Multiple races
- ❑ American Indian or Alaska Native
- ❑ Native Hawaiian or other Pacific Islander

LANGUAGE:
- ❑ English
- ❑ Spanish
- ❑ Italian
- ❑ French
- ❑ Japanese
- ❑ Portuguese
- ❑ Russian
- ❑ ________

INSURANCE INFORMATION:

PRIMARY INSURANCE CO. NAME_______________________________________
ID #_________________________ GROUP # _______________________________
ADDRESS____

SECONDARY INSURANCE CO. NAME ____________________________________
ID #________________________ GROUP # _______________________________
ADDRESS____

IS THIS WORK RELATED? ______ AUTO ACCIDENT?_______ OTHER ACCIDENT

I authorize all medical and/or surgical benefits, including Major Medical, Medicare, private insurance or health plans to COASTAL NEUROSURGERY. I am responsible for all charges incurred for my medical care. If Coastal Neurosurgery, P.A. is unable to collect the monies due us in a reasonable time, a finance charge of 1.5% per month will be added to your balance each month. If your account is sent to a collection agency, all collection costs and legal fees will be added to your account. I authorize the release of any medical information necessary to process my claim.

PLEASE SIGN__________________________________ DATE _______________

HIPPA DISCLOSURE

Coastal Neurosurgery, P.A. is committed to keep all information about you and your care private. We will notify you if there is any compromise to the security or privacy of your health, insurance or financial information (i.e., a "Red Flag" or "Breach"). We may use medical information about you to help with and coordinate your treatment with other doctors, nurses, therapists or other medical personnel.
If there are any health care professionals that you do **NOT** want us to release information to, please list:

____
____
____
____

We may be required to disclose medical information about you to insurance companies when required for payment or reimbursement for services. You have a right to inspect, read or obtain a copy or limit the distribution of your medical record.
To contact you with appointment, lab or test information we may need to call you by phone. If you are not available, can we leave appointment and lab or test results.
1. On your answering machine or voice mail? (circle one) YES NO
2. With a person who answers your phone? (circle one) YES NO

Is there anyone who might answer the phone that we should **NOT** leave this information with, please list:

__________________________________ __________________________________
__________________________________ __________________________________

If you have any questions about your medical record or privacy, you may read a more detailed description, available on request. Dr. Hartwell is the "Privacy Officer" but anyone on staff can answer your questions.

Please sign to show you understand the above:

Signature: ___________________________________ Date ________________