Dickinson
Neurological
Surgery

Brain & Spine Specialist

Patient Name: ________________ DOB: __________ Date: __________

Maiden Name: ________________ Sex: ☐ Male ☐ Female

Address: ________________

☐ Home Phone Number: (____)__________

________________

☐ Cell Phone or Alt Number (____)__________

☐ Alternative phone Number (____)__________

***Please mark above best contact number***

Social Security #: ________________ Email Address: ________________

**used to enroll you in Patient Portal where you can view results/ correspondence from doctor*

Ethnicity: ________________ Language: ________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact Name: ________________

Relationship to you: ________________ Phone Number: (____)__________

Name of your pharmacy: ________________ Phone Number: (____)__________

Primary Insurance ________________ ID# ________________ Group# __________

Secondary Insurance ________________ ID# ________________ Group# __________

Primary Care Doctor: ________________ Phone # (_____) __________

Doctor who referred you to us? ________________ (write same if it was your PCP)

Phone # of referring doctor (______) ________________

Mountain View Hospital
PROUD TO BE PHYSICIAN OWNED

# Authorization of Medical Records Release of Information Disclosure

*Please complete all sections of the form and attach required documentation to ensure timely processing*

I, ______________________ *(Patient/Patient Representative)*, authorize ______________________ *(Facility/Department)*

to release protected health information (medical records) for the individual named below:

**Patient Last Name:**______________________ **Patient First Name:** ______________________

**Patient Date of Birth:**__________ **Phone Number:**__________ **Previous Last Name** (If applicable): __________

**Street Address:**______________________ **City:**__________ **State:**__________ **Zip Code:** __________

**The Purpose of this disclosure is:**

☐ Medical Care or Consultation ☐ Billing or Claims Payment ☐ Personal Use ☐ Legal ☐ Other: __________

**Date(s) of Service:** *from*______________ *thru* ______________

**Information to be released:** *(A copy fee of $1.00 per report will be charged if applicable)*

☐ Lab Reports ☐ Radiology Reports: Disc Images_____Reports _____ ☐ EKG ☐ Operative Reports ☐ Itemized Bills
☐ Chart Notes (Face sheet, History & Physical, Operative Report, Discharge Summary, Consultations, and Discharge Instructions)
☐ Other: ______________________________

I understand that if my medical or billing record contains information in reference to the conditions described below, **I must agree to the release by initialing on each applicable line:**

_____ HIV/AIDS testing or treatment
_____ Psychiatric treatment (excluding psychotherapy notes)
_____ Genetic testing records
_____ Sexually transmitted diseases
_____ Drug or Alcohol Abuse Records (diagnosis, treatment, or referral, excluding counseling notes)
_____ Hepatitis B or C testing

**Information to be released to:** ☐ Self - same as above information

**Name of Third Party Receiving Records:** ______________________________

**Phone Number:**______________________ **Fax Number:**______________________

**Street Address:**______________________ **City:**__________ **State:**__________ **Zip Code:** __________

This authorization will expire in one (1) year unless an earlier date is specified: ______________________

*(continued on reverse side)*

Patient Sticker
Last______________
First______________
DOB______________
MRN______________



*PART OF THE MEDICAL RECORD. SCAN AFTER COMPLETION.*

Mountain View Hospital
PROUD TO BE PHYSICIAN OWNED

# Authorization of Medical Records Release of Information Disclosure

*Please complete all sections of the form and attach required documentation to ensure timely processing*

I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

I understand that I may revoke this authorization at any time by giving written notice to the Director of Health Information Management, 2325 Coronado St., Idaho Falls, ID 83404. I understand that revocation will not affect any action **Mountain View Hospital** took by relying on this authorization before they received my written notice.

I understand that this authorization to use or disclose protected health information is voluntary and **Mountain View Hospital** cannot deny or withhold health care services if I do not sign the authorization, except if the authorization is required for a research study in which I am enrolled, or if the service is solely for a third-party (pre-employment physical, etc.).

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and genetic information.

Signature of Patient: ______________________________ Date/Time: __________

☐ *Patient unable to sign:* ______________________________
*(Reason)*

*Authorized Agent Printed Name:* ____________________ *Relationship:* ______________

*Signature of Authorized Agent:* ______________________ *Date/Time:* __________

Name of Witness: ______________________________ Title: __________

Signature of Witness: ______________________ Date: ________ Time: ______

**For Staff Use**

**Records to be released via** ☐ US Mail ☐ Fax ☐ Personal Pick-up ☐ Emailed Paper Copies (including faxes CD/DVD)

**Form of ID or Proof Submitted:**

- ☐ Driver's License
- ☐ Guardianship/Conservator Orders
- ☐ Durable Healthcare Power of Attorney
- ☐ Other: ______________________________
- ☐ Birth Certificate
- ☐ Death Certificate
- ☐ Signature Verification

Patient Identification or Proof of Authority to Authorize Release verified/processed by:

Printed Name: ____________________ Title: ______________ Date: __________

Patient Sticker
Last ______________
First ______________
DOB ______________
MRN ______________



*PART OF THE MEDICAL RECORD. SCAN AFTER COMPLETION.*

Dickinson Neurological Surgery

Brain & Spine Specialist

Patient Name: ______________________ DOB: ____________ Date: ______________

Witness Signature Date

## Allergies

**Any allergies to medications?** YES /NO

***If yes, please list medication and describe reaction:***

---------------------------------------------------------------------------------------------

---------------------------------------------------------------------------------------------

Are you allergic to iodine or contrast (dye used for imaging)? YES/NO

Are you allergic to eggs? YES /NO

Are you allergic to gelatin? YES /NO

Are you allergic to yeast? YES/NO

## Surgery List

| Type of Surgery | Location | When |
|---|---|---|
| (Example) Knee Surgery | right | 2012 |
| | | |
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**Use back of sheet if necessary*

Dickinson Neurological Surgery

Brain & Spine Specialist

Patient Name: ______________________ DOB: __________ Date: __________

**Past Medical History:** Please check all that apply

☐ Cancer ☐ Diabetes ☐ Thyroid Disease ☐ Heart disease ☐ Hypertension

☐ Hepatitis ☐ Seizures ☐ Kidney stone ☐ Kidney Disease ☐ Dialysis

Additional Disease or Illness: ______________________________

**Family History**: *Do the following conditions run in your family?*

**Please circle Yes/No and list which family member(s).**

**Please mark A-Alive or D-Deceased next to family member**

Kidney Disease: YES /NO Type ______________ Family member(s) ______________

Kidney Stones: YES /NO Family member(s) ______________________________

Dialysis: YES /NO Family member(s) ______________________________

Hypertension: YES /NO Family member(s) ______________________________

Heart Disease: YES /NO Family member(s) ______________

Diabetes: YES /NO Family member(s) ______________

Cancer: YES/NO Type: ______________ Family member(s) ______________

Additional Disease or Illness: ______________________________

______________________________________________________

**Smoking History:**

Please circle one: NEVER SMOKED CURRENT SMOKER FORMER SMOKER

**Alcohol History:** Please circle usage description you feel best represents your intake of the following alcoholic beverages. YES/ No ______________________________

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## Medication List

**Please list all of the medications you are currently taking below.**

| MEDICATION INCLUDING MILLIGRAMS / STRENGTH | HOW MUCH | HOW OFTEN |
|---|---|---|
| (FOR EXAMPLE ONLY) Tylenol 500mg | 2 tablets | Every 8 hours |
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NAME: ______________________ DOB: _____________ DATE______________

Are you **CURRENTLY** experiencing the following symptoms **TODAY**? ***PLEASE CIRCLE***

**What are we seeing you for today:** ________________
________________________
________________________
________________________

**Constitutional**
- Chills
- Fever
- Weight Gain
- Weight Loss
- Fatigue

**Eyes**
- Blurry vision
- Eye pain
- Swelling
- Double Vision

**Ears, Nose, Mouth, Throat**
- Ringing in Ears
- Sore Throat
- Congestion

**Cardiovascular**
- Chest pain
- Swelling of legs

**Gastrointestinal**
- Abdominal pain
- Loss of control of bowels
- Nausea/Vomiting

**Respiratory/Lungs**
- Shortness of Breath
- Productive Cough
- Wheezing
- Non-Productive Cough

**Musculoskeletal**
- Back pain
- Joint pain
- Joint stiffness
- weakness
- Decreased ROM
- Neck Pain

**Integumentary**
- Itching
- Rashes
- Skin color changes

**Neurological**
- Headaches
- Tingling
- Loss of consciousness
- Tremors
- Feeling faint without loss of consciousness
- Feeling confused/disoriented
- Loss of Balance
- Weakness

**Endocrine**
- Increased thirst
- Excessive urination
- Decreased appetite
- Change in taste of food

**Hematologic/Lymph**
- Bleeding easily
- Swollen glands
- Bruising

**Allery/Immunologic**
- Hives
- Sneezing

**Office use only**
BP ______________
PULSE ____________
O2 ______________
WEIGHT ___________
HEIGHT ___________

Who is your PCP?
________________________

Pharmacy:
________________________

**Pain Scale: 0-10:** __________

**DR USE ONLY**
________________________
________________________
________________________
________________________
________________________
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________________________
________________________