

# PATIENT DEMOGRAPHIC INFORMATION

Please Print

PATIENT'S NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ APT # (if applicable) \_\_\_\_\_ P.O. BOX (if applicable) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PH (\_\_\_\_\_) \_\_\_\_\_ WORK PH (\_\_\_\_\_) \_\_\_\_\_ CELL PH (\_\_\_\_\_) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ PATIENT'S SS # \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_

PATIENT'S EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

SPOUSE'S NAME (or parent if minor or dependent child) \_\_\_\_\_

IS THE CONDITION YOU ARE BEING TREATED FOR RELATED TO WORK, AUTO INJURY OR OTHER TYPE OF INJURY? \_\_\_\_\_

IF SO, PLEASE EXPLAIN \_\_\_\_\_

DATE OF INJURY \_\_\_\_\_ HAS A CLAIM BEEN FILED WITH YOUR EMPLOYER OR INSURANCE CARRIER? \_\_\_\_\_

ARE YOU REPRESENTED BY LEGAL COUNSEL FOR THIS INJURY? \_\_\_\_\_

## INSURANCE INFORMATION

### PRIMARY INSURANCE

INSURANCE COMPANY NAME \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ POLICY HOLDER'S SS # \_\_\_\_\_

CONTRACT # \_\_\_\_\_ GROUP # \_\_\_\_\_

### SECONDARY INSURANCE

INSURANCE COMPANY NAME \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ POLICY HOLDER'S SS # \_\_\_\_\_

CONTRACT # \_\_\_\_\_ GROUP # \_\_\_\_\_

### THIRD INSURANCE

INSURANCE COMPANY NAME \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ POLICY HOLDER'S SS # \_\_\_\_\_

CONTRACT # \_\_\_\_\_ GROUP # \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

HOME PH (\_\_\_\_\_) \_\_\_\_\_ WORK PH (\_\_\_\_\_) \_\_\_\_\_ CELL PH (\_\_\_\_\_) \_\_\_\_\_

Neurosurgery Division  
 E. Malcolm Field, M.D.  
 Gerald R. Schell, M.D.  
 Naman Salibi, M.D.  
 Steve Lackie, PA-C, MPH



Saginaw Valley Neurosurgery, PLLC

Medical Arts Three, Suite 301 • 4677 Towne Centre Road  
 Saginaw, Michigan 48604 (989) 799-8712 • Fax - (989) 791-4216

Pain Management  
 Joseph Chatfield, D.O.

Medical History Form

Patient Last:			First:		M.I.:		DOB		
Requesting Physician		Primary Care Physician							
Current Weight		Current Height		Hand Dominance <input type="checkbox"/> R <input type="checkbox"/> L		Glasses <input type="checkbox"/> Y <input type="checkbox"/> N			
What problem brought you into our office today:									
How long have you been having this problem? Days, weeks, months, years.									
What were you doing when this problem first occurred?									
Is this problem associated with:			<input type="checkbox"/> Numbness		<input type="checkbox"/> Weakness		<input type="checkbox"/> Tingling		
Describe the location of the pain you are experiencing.									
Describe the type of pain you are experiencing:				<input type="checkbox"/> Sharp		<input type="checkbox"/> Dull		<input type="checkbox"/> Burning	
<input type="checkbox"/> Pressure		<input type="checkbox"/> Other		<input type="checkbox"/> Describe					
Do any of the following increase your pain level?				<input type="checkbox"/> Standing		<input type="checkbox"/> Sitting		<input type="checkbox"/> Walking	
<input type="checkbox"/> Twisting		<input type="checkbox"/> Lifting		<input type="checkbox"/> Stair Climbing		<input type="checkbox"/> Coughing or Sneezing		<input type="checkbox"/> Bending	
What relieves the pain or discomfort?									
Has this problem affected your ability to perform daily activities?				<input type="checkbox"/> Yes		<input type="checkbox"/> No		If yes, what?	
Have you missed work due to this problem?				<input type="checkbox"/> Yes		<input type="checkbox"/> No		Occupation:	
Does your work involve any of the following?				<input type="checkbox"/> Twisting		<input type="checkbox"/> Heavy Lifting		<input type="checkbox"/> Repetitive Bending	
Have you had this problem in the past?				<input type="checkbox"/> Yes		<input type="checkbox"/> No		If yes, for how long?	
Diagnostic studies-give date and facility				<input type="checkbox"/> MRI		<input type="checkbox"/> CT		<input type="checkbox"/> X-ray	
<input type="checkbox"/> Myelogram		<input type="checkbox"/> Angiogram		<input type="checkbox"/> Sleep Study		<input type="checkbox"/> Ultrasound		<input type="checkbox"/> EEG	
Treatments attempted-please include duration				<input type="checkbox"/> Bed Rest		<input type="checkbox"/> Chiropractic treatment			
<input type="checkbox"/> Physical therapy		<input type="checkbox"/> Traction		<input type="checkbox"/> Ice		<input type="checkbox"/> Heat		<input type="checkbox"/> Massage	
<input type="checkbox"/> Cortisone/epidural injections									



**On the next page please place an "X" next to any that apply.**

CONSTITUTIONAL SYSTEM:		CARDIOVASCULAR:	
<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	Chest pains
<input type="checkbox"/>	Weight change	<input type="checkbox"/>	Chest pain on exertion
<b>NEUROLOGICAL:</b>		<input type="checkbox"/>	Edema
<input type="checkbox"/>	Coordination/balance	<input type="checkbox"/>	Heart murmur
<input type="checkbox"/>	Claudication (leg pain standing/walking)	<input type="checkbox"/>	Heart palpitations
<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	Light-headedness	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Vertigo (whirling/rotational)	<b>GASTROINTESTINAL:</b>	
<input type="checkbox"/>	Visual disturbance	<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	Double vision	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	Difficulty with memory	<input type="checkbox"/>	Heart burn
<input type="checkbox"/>	Transient ischemic attack	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	Tremor	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Generalized weakness	<input type="checkbox"/>	Vomiting blood
<input type="checkbox"/>	Paresthesias	<b>GENITOURINARY:</b>	
<input type="checkbox"/>	Bowel incontinence	<input type="checkbox"/>	Dysuria (painful urination)
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Urinary frequency
<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Urinary infections
<input type="checkbox"/>	Urinary incontinence	<input type="checkbox"/>	Urinary urgency
<input type="checkbox"/>	Urinary retention	<input type="checkbox"/>	Venereal disease
<b>EYES:</b>		<input type="checkbox"/>	Breast lumps
<input type="checkbox"/>	Corrected vision	<input type="checkbox"/>	# of pregnancies _____
<input type="checkbox"/>	Glasses/contacts <input type="checkbox"/> Lasek	<input type="checkbox"/>	Hematuria (blood in urine)
<input type="checkbox"/>	Excessive tearing	<b>MUSCULOSKELETAL:</b>	
<b>EARS/NOSE/THROAT/MOUTH:</b>		<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Colds	<input type="checkbox"/>	Joint pain
<input type="checkbox"/>	Dentures	<input type="checkbox"/>	Muscle cramping
<input type="checkbox"/>	Gingival (gums) bleeding	<input type="checkbox"/>	Muscle pain
<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	Muscle weakness
<b>RESPIRATORY:</b>		<b>ENDOCRINE:</b>	
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Nipple discharge
<input type="checkbox"/>	Difficulty breathing (allergic)	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	Wheezing	<b>HEMATO-LYMPHATIC:</b>	
<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Bloody sputum	<input type="checkbox"/>	Bleeding tendency
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Blood clots/DVT
<input type="checkbox"/>	COPD	<b>PSYCHIATRIC:</b>	
<b>INTEGUMENTARY (SKIN):</b>		<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Itching	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Rash	<input type="checkbox"/>	Hallucinations
<input type="checkbox"/>	Hives	<input type="checkbox"/>	Attention deficit disorder
Signature: _____		<input type="checkbox"/>	Mood swings
		<input type="checkbox"/>	Schizophrenic
		Date: _____	

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Medical Arts Three ~ Suite 301  
4677 Towne Centre Road  
Saginaw, Michigan 48604-2806  
989~799~8712  
Fax 989~791~4216

Neurosurgery Division

Neurology Division  
Iftikhar A. Khan, M.D.

E. Malcolm Field, M.D.  
Gerald R. Schell, M.D.

Pain Management  
Joseph Chatfield, D.O.

PRINT PATIENT NAME: \_\_\_\_\_

CHART NUMBER: \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:**

I hereby authorize my insurance company to pay directly to SAGINAW VALLEY NEUROSURGERY, P.L.L.C. surgical and/or medical benefits, if any, otherwise payable to me for services rendered.

\_\_\_\_\_  
**Signature:** Insured/Legal Guardian of Patient

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Insurance Company Name

\_\_\_\_\_  
Insurance Company Address

\_\_\_\_\_  
Policy Number:

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize SAGINAW VALLEY NEUROSURGERY, P.L.L.C. to release my medical information to:

\_\_\_\_\_  
(Insurance Company Name) and may not be used for any other purpose or released to any other person(s) without my written consent.

This release specifically allows the release of the following information. **If you do not wish any of the following to be released, please initial the appropriate box.**

\_\_\_\_\_ Any record of treatment for Drug and/or Alcohol dependency or abuse;

\_\_\_\_\_ Any record of Mental Health treatment;

\_\_\_\_\_ Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases.

This release is effective for one year from the date of execution, however, it may be revoked by me at any time by providing notice in writing to the above named party.

\_\_\_\_\_  
**Signature:** Insured/Legal Guardian of Patient

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Patient Social Security Number:

\_\_\_\_\_  
Patient Date of Birth: