AVISTA
BRAIN & SPINE
INSTITUTE

Your appointment is scheduled:

Date: ______________________________

Time: ______________________________

Thank you for choosing Dr. Warren Roberts at Avista Brain & Spine Institute. We will make every effort to make your visit as pleasant as possible. As a neurosurgeon, Dr. Roberts treats surgical conditions of the brain, spine and peripheral nervous system. You have been referred to our office for evaluation of your neurosurgical condition and an explanation of possible treatment options, which might include surgery.

In order to make the best recommendations for your particular case, we may need additional tests, such as CT scans, X-rays, and MRIs. We also need to know your general medical condition and history, as these might effect the choice of treatments prescribed. We have included forms for you to complete prior to your appointment. It is very important that you complete these forms as accurately and completely as possible. If you have any questions about how to complete the forms, please call our office and we can assist you.

We are happy to discuss your case with your primary care provider or other doctors involved in your care. Please be sure to provide us with an accurate address and phone number for your medical provider(s), to insure the information is forwarded correctly.

To provide the most efficient care for all of our patients we ask that you direct all calls to our main line at (303) 661-4316

We have included additional information in this packet that you may find helpful. Please review it carefully.

We look forward to seeing you soon.

Sincerely,

Warren Roberts, MD

Warren Roberts, MD
Neurological Surgery

90 Health Park Drive, Suite 320
Louisville, Colorado 80027
303-661-4316 | *fax* 303-661-4345
www.AvistaBrainAndSpine.com

Dear Patient,

Avista Brain & Spine Institute is committed to meeting your neurosurgical health care needs. The following information will allow us to serve you better.

Office Hours: 9:00 a.m. – 5:00 p.m., Monday – Friday
Phone Number: (303) 661-4316
Fax Number: (303) 661-4345
Address: 90 Health Park Drive Suite 320
(We are located in the Avista I medical building at Avista Adventist Hospital)

Calls to the office:
If you have any questions or concerns, please feel free to contact our office. Someone will return your call as soon as possible, usually within 24 hours. Many times we return calls at the end of the day. If the matter is an emergency and cannot wait until the end of the day for a response, please let us know when you call.

Referrals (Insurance):
Many insurance carriers require a referral from your primary care provider (PCP) before you can see a specialist, such as a neurosurgeon. If a referral is not in place before your visit, your insurance can refuse to pay for the visit and you would be responsible for the bill. Therefore, we ask that you **always** check with your PCP, to be sure you have a current referral in place before each appointment. Please bring your insurance card to each visit and let us know as soon as possible if you change insurance companies.

Cancellation of appointments:
We understand that circumstances can occur that make it necessary for you to cancel or reschedule an appointment. Please contact us at least 24 hours ahead of time, if you need to cancel or reschedule your appointment. We often have people we can move up in the schedule if we know there will be an opening. Due to the nature of our specialty, we occasionally have to reschedule appointments when the doctor is called away to an emergency situation. We regret this inconvenience and will make every effort to notify and reschedule your appointment as soon as possible.

Your films (x-rays, MRI's CT scans, etc.):
It is **ABSOLUTELY NECESSARY** that your films (not just the reports) be available for your doctor to review at **each** office visit. We need to be able to compare your symptoms, your exam, and your test results, to make an accurate diagnosis and treatment plan. Your doctors will not see you if your films are not available. Unfortunately, we do not have the space to store everyone's film at our office, so we may ask that you keep your films and bring them to each visit. The exception is if surgery is being considered, in that case we would prefer to keep your films to insure they are available the day of surgery. Surgery would be canceled if the films were not available.

Test results:
We try to call with your test results as soon as they are available and reviewed by your doctor. However, because tests are performed at many locations throughout the region, there can be a delay in the results getting back to us. If we have not called with your test results within a week of completion of your test, please call us and we will locate the results and call you as soon as possible.

Prescription refills:
If you need a refill of a medication we prescribed for you, please contact your pharmacy and they will contact us. **Allow at least 24 hours for refills to be processed**. We will not process refills after 12:00 PM on Fridays.

Narcotic Medications:
All requests for prescriptions or refills of narcotic medications (including prescription pain medications, sleeping medications, tranquilizers, etc.) **MUST** be completed during office hours. For your safety, your chart must be available for review before a narcotic medication can be prescribed or refilled. **We will *NOT* refill or call in any narcotic prescriptions after hours or on weekends**. We will not process refills after 12:00 PM on Fridays. Again, please allow at least 24 hours to process the request.

Billing: We are happy to bill your insurance for services rendered. Should you have changes in your health coverage, please notify us immediately so that accurate billing can occur.

Disability: There will be a $10.00 service charge for completion of any disability/comprehensive return to work forms. This fee will be collected when you pick up your completed forms. Also note, we do not do disability ratings nor do we manage patients for long-term disability.

Thank you for allowing Dr. Warren Roberts to assist with your health care needs. We hope your experience with our practice is a positive one and results in the best possible outcome. We look forward to seeing you soon.

Sincerely,

Warren Roberts, MD

Avista Brain & Spine Institute

PATIENT INFORMATION

Please complete at home and bring with you to your appointment. *Today's Date:*____________

Name: Last:__________________________First:__________________MI:____Nickname______________

Date Of Birth:___________________ Age:______S.S.#__________________________ Sex M F

Phone: Home: (___)___________________Work:(___)_________________Cell (___)__________________

Home address____

City State Zip

Place of Employment: ____

Address____

City State Zip

Emergency Contact: __________________________ Phone (___)________________Relationship: ________

If Married, please provide the following spouse's information:

Name:____________________________Date of Birth:______________ S.S. #: ______________________

Place of Employment____ Phone (___)________________

Physicians Information - Important, please complete in full:

Referring Physician: ____ Phone (___)______________________

Address____

IF DIFFERENT FROM ABOVE: City State Zip

Primary Care Physician:____________________________________ Phone (___)______________________

Address____

City State Zip

Please identify any other physician you would like your neurosurgery evaluation sent to:

Physician Name:_______________________________________ Tel #:_____________________________

Physician Name:_______________________________________ Tel #:_____________________________

Please list what type of insurance you have: Is this injury the result of: **Please circle**

Automobile accident / Work injury / Other ________________________Claim #________________________

Date of Accident______________Adjuster name:______________________Phone (___)_______________

Insurance Name & Address____

Nurse Case Manager (if applicable)_________________________________ Phone (___)________________

Do you have an Attorney? Name____________________________________ Phone (___)________________

Primary Insurance Co: ____ Group#:__________________

Subscriber #_______________________ Relation to Patient :____________ Date of Birth:________________

Effective Date:__________ Policy Holder's Employer:__________________ Phone(___)_________________

Secondary Insurance Co: ____________________________________ Group#:_______________________

Subscriber #_______________________ Relation to Patient :____________ Date of Birth:________________

Effective Date:__________ Policy Holder's Employer:__________________ Phone(___)_________________

Medicare State ID#________________________ Medicaid State ID#________________________________

I consent to medical care and treatment for myself, my dependents, or for those whom I hold legal guardianship.

Deductibles, co-payments or coinsurance and payments for non-covered services are required at the time for service. Our office will only file a claim with an HMO or PPO with whom we have a contract.

I understand that accounts more than 90 days past due may be turned over to collection and any legal fees or costs will be my responsibility. I authorize payment of medical benefits to the undersigned or supplier for these services and all future claims.
I authorize the release of any information necessary to process this claim and all future claims.

____ ________________________

SIGNATURE (PATIENT/AUTHORIZED REPRESENTATIVE) DATE

CHIEF COMPLAINT

Reason for today's visit – please list your symptoms in order of severity:

____

____

Who has been treating you for this problem: ______________________________

Current problem is a result of: **CHECK ALL THAT APPLY**

___ Car Accident ___ Work Accident ___Other: ______________________________

Explain: ____

Have you ever had similar symptoms in the past? No Yes, explain: ______________

____

PAST MEDICAL HISTORY

Please circle any conditions you have been treated for:

High Blood Pressure Heart Disease High Cholesterol Congestive Heart Failure

Heart Attack Stroke Diabetes Asthma/COPD/Emphysema Thyroid Disease

Neurological disease: ____

Other: ____

____

Surgeries/Hospitalizations	YEAR	Surgeries/Hospitalizations	YEAR

Have you ever had problems with anesthesia? No Yes - If yes please describe:

____

FALL ASSESSMENT

1) Are you here because of a fall? **Yes No**
2) Have you had recurrent falls? **Yes No** (If yes, define # per year________)
3) Do you have difficulty walking or with your balance? **Yes No**
4) Do you have a fear of a fall? **Yes No**

If you have answered yes, to any of these questions, please ask a staff member for a "Fall Screening Questionnaire" upon your arrival to our office. We are mandated by Joint Commission of Accreditations National Safety Goals to complete this evaluation. Thank you.

Height: ____________________ **Weight:** ____________________

ALLERGIES:

Medication: ________________________________ **Reaction:** __________________________________

Medication: ________________________________ **Reaction:** __________________________________

Medication: ________________________________ **Reaction:** __________________________________

Medication: ________________________________ **Reaction:** __________________________________

Other allergies (tape, food, etc.): ____

MEDICATIONS: Please list all medications you are taking, including over the counter medications, such as: aspirin, Tylenol, Advil, Aleve, herbal preparations, etc.

Are you taking anything to thin your blood? **Yes** **No**

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Medication: ______________________________ _______mg. - times taken each day ______

Name of doctor(s) prescribing medications: ____

____

____

Are you currently being treated by any other doctor besides your primary care doctor?
Yes **No** (If yes, please list their names below and specialty, i.e. cardiologist, etc)

Physician Name:	**Speciality**
_____________________________________	__________________________
_____________________________________	__________________________

FAMILY MEDICAL HISTORY

Please indicate any **immediate blood relative** (parents, brother/sister, grandparents, children) who has/had the following:

Heart disease/Heart attack	
High blood pressure	
Stroke	
Diabetes	
Cancer (what type?)	
Neurological disorders	
Other:	

SOCIAL HISTORY

Occupation: ____

Usual activities required (work and/or recreation): ______________________________

Marital Status: Married Widowed Divorced Single

Do you have children? No Yes How many? _________ Do they live with you? ________________

Are you exclusively responsible for anyone's care? No Yes, Who? ___________________________

Do you have anyone to help you at home if you have surgery? No Yes, Who? _________________

Do you smoke? ___ No, I have never smoked.

___ Yes, I have smoked ____ packs of cigarettes a day for ____ years

___ No, I quit smoking ___ yrs. ago, I smoked ___ packs a day for ___ yrs

___ Yes, I smoke cigars or a pipe, ____ a day for ____ years

Do you drink alcohol?___ No___ Yes, _______ drinks a day week month

Do you use any street drugs? ___ No, never
___ Yes, please list: ____

Are you at risk for AIDS or Hepatitis (e.g. sexual orientation, drug abuse, previous blood transfusion)?

No Yes, please explain: ____

Do you have advanced directives? ___ yes ___ no
(Living will, durable power of attorney for medical decisions)

If No, would you like information regarding advanced directives? ___ yes ___ no

Given pamphlet: __________________

REVIEW OF SYSTEMS:
Have **YOU** ever had any of the following conditions: **CHECK ALL THAT APPLY**

General:
- Weight loss (unintentional) ____
- Unexplained fever ____
- Night sweats ____

HEENT (HEAD):
- Glaucoma ____
- Cataracts ____
- Hearing loss ____
- Balance problems/Dizziness ____
- Frequent sinus problems ____
- Frequent sore throat ____

Other/Explain ____________________________

Cardiovascular (HEART):
- Heart attack ____
- Chest pain or angina ____
- High blood pressure ____
- High cholesterol ____
- Heart murmur ____
- Irregular heart beat ____
- Swelling of feet or hands ____

Date of Last EKG/stress test __________________
Other/Explain ____________________________

Respiratory (LUNGS):
- Asthma ____
- Emphysema ____
- Chronic bronchitis ____
- Shortness of breath at rest ____
- Bloody sputum ____
- Recent pneumonia ____
- Chronic cough ____
- Sleep apnea ____
- Oxygen use ____

Other/Explain ____________________________

Gastrointestinal (DIGESTIVE):
- Frequent nausea/vomiting ____
- Blood in vomit or stools ____
- Liver disease ____
- Jaundice ____
- Ulcer or gastritis ____
- Esophageal reflux (GERD) ____
- Disease of the colon ____
- Constipation/Diarrhea ____
- Frequent Stomach pain ____

Other/Explain ____________________________

Genitourinary:
- Recent bladder infections ____
- Blood in urine ____
- Urinary frequency/urgency ____
- Incontinence ____
- Prostate disease ____
- Kidney disease ____

Other/Explain ____________________________

Neuro/muscular:
- Low back pain ____
- Leg pain/numbness/weakness ____
- Neck pain ____
- Arm pain/numbness/weakness ____
- Frequent headache/migraine ____
- Seizures ____
- Problem with memory ____
- Difficulty with speech ____
- Confusion ____
- Double or blurred vision ____
- Neurological illness (MS, ALS, Parkinson's, etc.) ____
- Stroke/TIA ____

Other/Explain ____________________________

Endocrine (GLANDS):
- Diabetes ____
- Thyroid disease ____
- Hormone problems ____

Other/Explain ____________________________

Hematological/Immune (BLOOD):
- Anemia ____
- Bleeding problems ____
- Immunological disorders (Lupus, RA, HIV/AIDS, etc) ____

Other/Explain ____________________________

Psychological:
- Depression/anxiety/bipolar ____

Other/Explain ____________________________

Comments/additional medical conditions not covered above:

____

____

____

Please answer the following question with regard to possible future testing:

	YES	NO	N/A
Are you pregnant?	___	___	___
Are you claustrophobic?	___	___	
Are you a welder/metal worker?	___	___	
Have you worked with metal in the past?	___	___	

Please circle any of the following that you have: Cardiac pacemaker - Cardiac valve prosthesis –Vena cava umbrella - Automated internal cardiac defibrillator - Nitroglycerin patch - Aneurysm clip - Neurostimulator - Implanted pump - any metal in your body

The information provided on this form is accurate to the best of my knowledge.

________________________________ ________________________________

Patient Signature *Date*

I have reviewed the above information with the patient.

________________________________ ________________________________

Provider Signature *Date*