# WELLSPINE, P.A.

**FRANCISCO J. BATLLE, M.D.**
*Neurological Surgery*

## INSURED PATIENT'S INFORMATION

Name_____ Date:_____
(First) (Middle) (Last)

Date of Birth:_____ Social Security#:_____Sex: ( )M ( )F
Home Phone: (____)_____ Cell Phone:_____
Address:_____
(Street) (City) (State) (Zip)
Referring Doctor:_____Phone:_____

## PATIENT'S EMPLOYER INFORMATION

Employer's Name:_____
Address:_____
(Street) (City) (State) (Zip)
Patient's Occupation:_____
Work Contact Person:_____Contact Phone:_____

## GUARANTOR (POLICY HOLDER) INFORMATION

Guarantor Name:_____
Address:_____
(Street) (City) (State) (Zip)
Guarantor's Date of Birth:_____Social Security#:_____
Guarantor's Employer Name:_____
Address:_____
(Street) (City) (State) (Zip)

## INSURANCE INFORMATION

**Primary Insurance Co. Name:**_____Policy#:_____
Group Name:_____Group#:_____
Effective Date:_____Expiration Date:_____
Patient's Relationship to Policy Holder:_____Policy Holder:_____
**Secondary Insurance Co. Name:**_____Policy #:_____
Group Name:_____Group #:_____
Effective Date:_____Expiration Date:_____
Patient's Relationship to Policy Holder:_____Policy Holder:_____

## EMERGENCY CONTACT INFORMATION

Name:_____Relationship:_____
(First) (Middle) (Last)
Home Phone:_____ Cell Phone:_____

What is the reason for today's visit?_____
Have you suffered any previous injury(i.e.:car accident/work related injury) to your neck/mid/lowback prior to this visit? When?_____

**EXPLANATION OF PAYMENT POLICY & INSURANCE FILING PROCEDURES**

I hereby authorize Wellspine, P.A. to release medical information and necessary date pertinent to the filing of insurance papers in the interest of the patient named above and facility. I authorize my insurance carriers to pay benefits directly to Wellspine, P.A. on any unpaid services filed on my behalf by Wellspine, P.A. I understand that I AM RESPONSIBLE for payments to Wellspine, P.A for charges for the above patient regardless of my insurance coverage. I also understand that Wellspine, P.A. is not ultimately responsible for collecting my insurance or negotiating settlements of claims.

**PATIENT'S SIGNATURE**_____ **DATE:**_____

**8215 Westchester Dr * Dallas, Texas 75225 * Phone: (214) 819-9600 * Fax: (214) 819-9601**

**WELLSPINE, P.A.**
LEADING SOLUTIONS THROUGH PRECISION TECHNOLOGY

**FRANCISCO J. BATLLE, M.D.**
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## DISCLAIMER

**The Staff at Wellspine, P.A. has verified your insurance coverage. At this point it is a quote of medical benefit coverage and not a guarantee of payment until the claim submitted has been reviewed. In the event of your insurance denies payment you are responsible for the balance in full. At the time of your visit you are responsible for the co-payment where applicable and/or the deductible (if not satisfied for the current year), according to information from your insurance company.**

**Signature** _____ **Date** _____

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# HEALTH HISTORY

**(Confidential)**

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Date of last physical examination: _____

What is the reason for today's visit? _____

Have you suffered any previous injury to your neck/mid/lowback prior to this visit?

When? _____

_____

_____

**SYMPTOMS** (mark symptoms you currently have or have had in the past year)

**General**

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

**Muscle/Joint/Bone**

Pain, weakness or numbness in:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands

**Genito-Urinary**

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

**Gastrointestinal**

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

**Cardiovascular**

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Shoulders
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

**Eye, Ear, Nose, Throat**

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

**Skin**

- ☐ Bruise easily
- ☐ Irregular heart beat
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

**MEN ONLY**

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump n testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

**WOMEN ONLY**

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____.

- ☐ Hives

Date of last Pap Smear _____

Have you had a mammogram?

Are you pregnant? _____.

Number of children _____.

**CONDITIONS** (mark each condition you have or have had in the past.)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

| **MEDICATIONS** (list medications you are currently taking) | **ALLERGIES** (to medications or substances) |
|---|---|
| | |
| | |
| | |
| Pharmacy Name | Phone |

(All information is strictly confidential)

**FAMILY HISTORY (Fill in health information about your family)**

| Relation | Age | State of Health | Age at Death | Cause of Death | Check (X) if your blood relatives had any of the following: Disease | Relationship to you |
|---|---|---|---|---|---|---|
| Father | | | | | Arthritis, Gout | |
| Mother | | | | | Asthma, Hay Fever | |
| Brothers | | | | | Cancer | |
| | | | | | Chemical Dependency | |
| | | | | | Diabetes | |
| | | | | | Heart Disease, Strokes | |
| Sisters | | | | | High Blood Pressure | |
| | | | | | Kidney Disease | |
| | | | | | Tuberculosis | |
| | | | | | Other | |

**HOSPITALIZATIONS**

| Year | Hospital | Reason for Hospitalization and Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PREGNANCY HISTORY**

| Yr of Birth | Sex | Complications if any |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Have you ever had a blood transfusion?** ☐ Yes ☐ No

**If yes, please give approximate dates**

**HEALTH HABITS: Check (X) which substances you use and describe how much you use.**

| | |
|---|---|
| | Caffeine |
| | Tobacco |
| | Drugs |
| | Other |

| SERIOUS ILLNESS / INJURIES | DATE | OUTCOME |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**OCCUPATIONAL CONCERNS**

**Check (X) if your work exposes you to the following:**

| | |
|---|---|
| | Stress |
| | Hazardous Substances |
| | Heavy Lifting |
| | Other |

**Your occupation:**

**I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.**

**PATIENT SIGNATURE** **DATE** **PHYSICIAN'S SIGNATURE** **DATE**

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## MEDICATION GUIDELINES

At some point in your treatment, Dr. Batlle may prescribe medication to help control your pain. This will likely be a controlled substance or narcotic. These medications have a high potential for abuse and misuse and are closely controlled by the local state and federal governments. If used excessively, the medications can cause serious adverse effects such as lethargy, respiratory depression, liver failure and even death. Certain guidelines must be followed in order for patients to receive these medications. Please read carefully and sign below to indicate that you will comply with guidelines. A copy of this agreement will be placed in your chart.

- Read the instructions on your medication bottle. Take the medication only as directed.
- No prescription will be filled before it is due.
- If your medication is due please call your pharmacy and give them the request. The pharmacy will call us for the approval.
- If your refill is due on a weekend, please call your pharmacy a couple of days early so that our office may authorize the refill for Saturday or Sunday as appropriate.
- Most calls to pharmacies are returned before the end of the business day.
- If your medication is lost or stolen, the office will be unable to refill it early. It is the patients' responsibility to keep narcotics and other medications in a safe place.
- No prescriptions will be refilled after 3:00 p.m. on Fridays. No prescription will be refilled on Nights, Weekends, and Holidays or on an "Emergency" basis.
- All patients are expected to abide by the dosing directions that are on your prescription bottle. It is not our intent that you should be in pain. If you feel that your medication is not controlling your discomfort please call our office.

**I have read the guidelines and agree to abide by the recommendations.**

**Patient Signature** **Date** **Witness Signature** **Date**


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**Consent to the Use and Disclosure of Health Information**
**for Treatment, Payment, or Healthcare Operations**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

____Accepted _____ Denied

Signature_____

**Date:** _____

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