Pennsylvania
Brain & Spine Institute

New Patient Form

Name:

DOB:

Date:

Name of provider requesting consultation: _____

Reason for today's visit: _____

Review of Systems

Circle all that Apply						
Constitutional	unexpected weight loss	weight gain	fever	chills	fatigue	night sweats
Eyes	corrective lenses	blurred/double vision	eye pain	redness	watering	floaters/spots
Ears/Nose/Throat	headaches	difficulty swallowing	nose bleeds	ringing in ears	earaches	loss of hearing
Cardiovascular	chest pain	palpitations	fainting	murmurs		
Respiratory	shortness of breath	wheezing	coughing	tightness in chest	inspirational pain	snoring
Gastrointestinal	heartburn	nausea vomiting	constipation	diarrhea	bloody/tarry stools	
Genitourinary	frequency urgency	difficult/painful urination		flank pain	bleeding	incontinence
Musculoskeletal	joint pain swelling	instability	stiffness	redness	heat	muscle pain
Skin	skin changes	poor healing	rash	itching	redness	
Neurologic	numbness/tingling	unsteady gait	dizziness	tremors	seizures	memory problems
Psychiatric	nervousness	anxiety	depression	hallucinations	other psychiatric illness	
Hematologic	easy bleeding	easy bruising				
Endocrine	excessive thirst	excessive urination	heat/cold intolerance			
Allergic	reaction to food	reaction to environment				

☐ None of the above apply to me

Pharmacy Name and Phone Number: _____

Medication Allergies

☐ No Known Drug Allergies ☐ Latex Allergy

_____

_____

_____

Other Allergies: _____

Medications with Dosages

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History

Have you ever had or do you now have any of the following listed conditions?

Diabetes	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Depression / Other Psych Illness	☐ Yes	☐ No
Cancer (Type)	☐ Yes	☐ No	Stroke or TIA	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Epilepsy / Convulsions	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Arthritis / Gout / Rheumatoid	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Emphysema / COPD / Asthma	☐ Yes	☐ No	Kidney Trouble / Dialysis / Prostate	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Reflux / Stomach / Bowel Problems	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No	Problems with Anesthesia	☐ Yes	☐ No
Heart Trouble / Chest Pain	☐ Yes	☐ No	Fibromyalgia	☐ Yes	☐ No
Cardiologist Name:			Other		

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Name: _____
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Past Medical History continued

Please list any prior Surgeries (with approximate dates):

_____ _____
_____ _____
_____ _____
_____ _____

Please list any prior Hospitalizations (with approximate dates):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family Medical History

(Inherited Diseases, Medical Events, Significant Medical Problems)

Mother's Medical Problems: _____

Father's Medical Problems: _____

Brothers'/Sisters' Medical Problems: _____

Maternal Grandmother's Medical Problems: _____

Maternal Grandfather's Medical Problems: _____

Paternal Grandmother's Medical Problems: _____

Paternal Grandfather's Medical Problems: _____

Social History

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

Employment status: ☐ Employed, occupation: _____

☐ Unemployed, Date of last regular job: _____

☐ Permanently Disabled, Date of Disability/Years Disabled _____

Use of Tobacco Products: ☐ Yes ☐ No Packs per Day _____

Alcohol Use: ☐ Yes ☐ No Number of Drinks per Week _____

Drug Use: ☐ Yes ☐ No Type _____

Patient Signature: _____ Date: _____

P.A. _____ *Pedro Aguilar, MD* _____ *Michael Horowitz, MD* _____ *Richard Spiro, MD* _____

Pennsylvania
Brain & Spine Institute

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161 Waterdam Road, Suite 120 • McMurray, PA 15317 724.942.3097 Fax: 724.942.3572

PLEASE COMPLETE FORM IN ENTIRETY

Demographic Information

Last Name | First Name | Middle Initial

Address | City | State | Zip Code

Social Security Number | Date of Birth | Sex: ☐ Male ☐ Female

Home Phone | Work Phone | Cell Phone | Email

Contact Preference: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Mail

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

May we leave detailed medical information on your voicemail? ☐ Yes ☐ No

Requesting Provider | Phone | Fax Number

Requesting Provider Address

PCP | Phone | Fax Number

PCP Address

Emergency Contact | Phone Number | Relationship

Insurance Information

Primary Insurance Company Name | Identification Number | Group Number

Insurance Company Address | City | State | Zip Code

Insurance Company Phone Number | Effective Date | Copay: OV$ | Copay: SP$

Subscriber's Name

Subscriber's Social Security Number | Subscriber's Phone Number | Date of Birth | Relationship

OVER >

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Insurance Information continued (if applicable)

Secondary Insurance Company Name | Identification Number | Group Number

Insurance Company Address | City | State | Zip Code

Insurance Company Phone Number | Effective Date | Copay: OV$ | Copay: SP$

Subscriber's Name

Subscriber's Social Security Number | Subscriber's Phone Number | Date of Birth | Relationship

ALL INFORMATION IS REQUIRED FOR PROPER BILLING

Accident Information (if applicable)

Insurance Company to be Billed | Date of Initial Accident

Billing Address: | City | State | Zip Code

Claim Type: ☐ Worker's Comp ☐ Auto ☐ Other _____

Claim Number | Contact Person | Contact Phone Number | Contact Fax Number

Employer: (if worker's compensation)

Description of Injury:

Patient Signature: _____ Date: _____