NEUROSPINE
SURGICAL CONSULTANTS

Today's Date: _____

PATIENT INFORMATION

DOB: _____

Patient Name: _____

Address: _____

_____

Cell #: _____

Sex (circle one) Female Male

In case of emergency, please contact:

Name: _____

Relationship: _____

Phone #: _____

MEDICAL SUMMARY

Medical Allergies: _____

_____

Major Illnesses: _____

_____

PHARMACY INFORMATION

Address: _____

_____

Phone #: _____

CONSENT TO TREAT

I understand that I have presented myself to NeuroSpine Surgical Consultants for evaluation and/or treatment of my Neurological or Spinal condition. I am aware that I may require necessary treatment during my episode of care. I further understand that all options will be discussed prior to the administration of such treatments.

Patient's signature: _____

Were you injured while working?
_____Yes _____No Date of Injury: _____

Is your visit related to an automobile accident?
_____Yes _____No Date of accident: _____

HIPAA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I can request a copy of this notice at any time. I have the right to review the notice prior to signing this consent. I have had the opportunity to receive and review the Notice of Privacy Practices of NeuroSpine Surgical Consultants.

Initials_____

I authorize the release of any and all medical information necessary for my medical care and to process medical claims. I understand that all fees incurred in the course of my treatment by NeuroSpine Surgical Consultants and/or its authorized agents are my responsibility. I hereby authorize the insurance companies to make payment directly to NeuroSpine Surgical Consultants for those fees I have not previously paid. Additionally, I agree to all charges not paid by my medical insurance companies are ultimately my responsibility. I authorize the use of my signature on insurance submissions.

☐ YES ☐ NO

Signature: _____

I give authorization for NeuroSpine Surgical Consultants' staff to contact the following person(s) and leave messages regarding appointments or test/surgery scheduling in the event I am unable to be reached at the number(s) I have provided.

Name: _____

Relationship: _____

Phone #: _____

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SURGICAL CONSULTANTS

Patient History of Present Problem

Patient name:_____ **Date:**_____

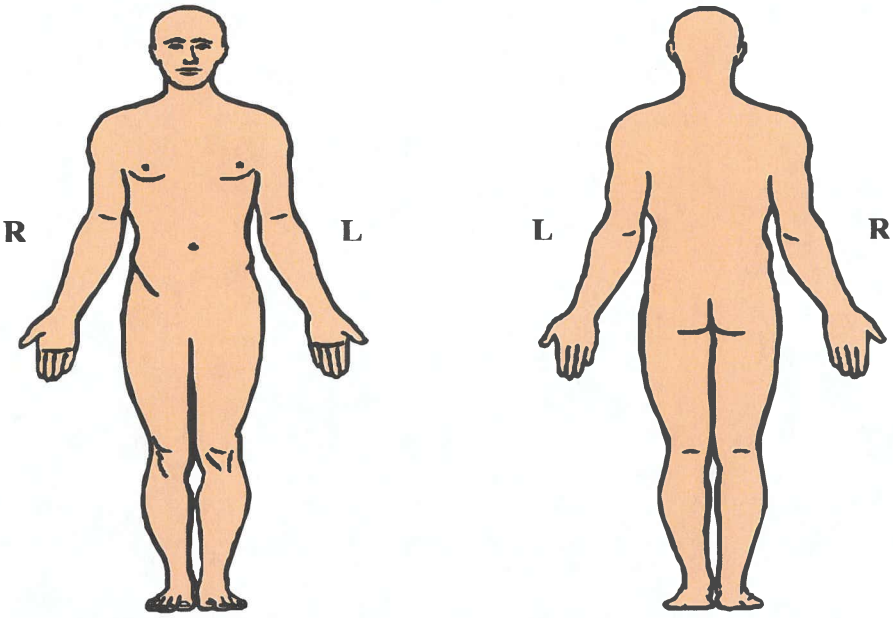
Age: _____ **Race:**_____ **R or L handed** **Sex: Male Female**

In one sentence or less, please state the reason you are seeking a surgical evaluation:

_____

Mark the areas on your body where you feel the described sensations by using the appropriate symbol.

Ache: ^^^^ **Numbness:** OOOO **Pins & Needles:** = = = = **Burning:** XXXX **Stabbing:** ////



Are you experiencing any of the following symptoms:

- ☐ Radiating pain
- ☐ Numbness (loss of sensation)
- ☐ Tingling
- ☐ Loss of control of bowels or bladder
- ☐ Weakness in arms or legs
- ☐ Gait changes
- ☐ Headaches
- ☐ Problems controlling your fingers

Please mark the level of your pain on the following scale:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Possible**

Since their onset, have the symptoms: ❑ Improved ❑ Remained the same/leveled off ❑ Progressively worsened

List two physical activities which aggravate your pain: _____

List two physical activities/positions which make the pain better: _____

Is the pain the result of an injury? ❑ Yes ❑ No ❑ Unsure – please explain:_____

If this is an injury, is it: ❑ Work related ❑ Motor vehicle related ❑ Other: _____

What is the date of injury? _____ If not an injury, date symptoms began:_____ Have you missed work because of your pain? ❑Yes ❑ No If yes, how long? _____

Briefly describe how your injury occurred or how the symptoms began:_____

_____

_____

When (date) did you begin to seek medical care for your symptoms? _____

Who did you seek treatment from (physician name/specialty):_____

Please list all other physicians you have sought treatment or opinions from:

_____

_____

Patient name:_____

Please mark all diagnostics done with dates: ❑ MRI _____ ❑ CT/Myelogram _____ ❑ X-Ray _____

❑ EMG/NVC _____ ❑ Other_____

What treatments have you tried to help alleviate your symptoms (Dates- only within the last year)

❑ Physical therapy* When:_____ ❑ Epidural Steroid Injections (ESI's)*When_____

❑ Over the Counter medication* When_____ ❑ Oral Steroids*When:_____ ❑ Heat /Ice* When_____

❑ Facet injections* When_____ ❑Chiropractic *When_____ ❑ Other_____* When:_____

Medication Information

List all medications to which you are allergic:

_____

Please list any medications & dosages you are currently taking (include over the counter and herbals).

_____ _____

_____ _____

Past Surgical History

Starting with the most recent, please list in date order any **SPINE** surgeries you may have had:

_____ _____

Date Operation Date Operation

Starting with the most recent, please list any other types of surgery you may have had:

_____ _____

Date Operation Date Operation

_____ _____

Date Operation Date Operation

Family History

Family Member	Living	Deceased	Age	Health Status or Cause of Death
Mother	❑	❑	____	_____
Father	❑	❑	____	_____
Brother/Sister	❑	❑	____	_____
Brother/Sister	❑	❑	____	_____
Grandmother (mom's)	❑	❑	____	_____
Grandfather (mom's)	❑	❑	____	_____
Grandmother (dad's)	❑	❑	____	_____
Grandfather (dad's)	❑	❑	____	_____

Social History

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

Occupation:_____ Do you have children? ❑ Yes ❑ No If yes, how many?_____

Do you live alone? ❑ Yes ❑ No If no, who lives with you?_____

Do you **smoke or Vape**? ❑ Yes ❑ No If Yes, how many packs per day? _____ For how long? _____

If you're a former smoker or vaper , how long ago did you quit? _____ How many packs per day were you smoking?_____

Do you drink **alcohol**? ❑No ❑Rarely ❑No, but I used to ❑Yes, daily ❑Yes, 1 or more times a week ❑Yes, socially

Are you at risk for AIDS (e.g. sexual orientation, history of drug use, previous blood transfusion)? ❑ Yes ❑ No

Health History/Review of Systems

Have you had or been told you have any of the following conditions or symptoms? Please check all that apply.

General
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Loss of appetite
- ☐ **Recent Fever**
- ☐ Recent fatigue
- ☐ Recent night sweats
- ☐ **HIV**

Eyes, Ears, Nose, Throat
- ☐ Frequent headaches
- ☐ Migraine
- ☐ Head Injury
- ☐ Vertigo
- ☐ Light headedness
- ☐ Visual loss
- ☐ **Double vision**
- ☐ Wear glasses/contact lenses
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ **Ear Drainage**
- ☐ Frequent nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Toothaches
- ☐ Frequent sore Throat
- ☐ Hoarseness
- ☐ Voice changes
- ☐ Neck swelling
- ☐ Neck stiffness\Any other disorder of the eyes, ears, nose or throat

Respiratory
- ☐ Shortness of breath with activity
- ☐ **Shortness of breath while lying flat**
- ☐ Shortness of breath awaking you at night
- ☐ **Wheezing**
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Pleurisy
- ☐ **Asthma**
- ☐ **Chronic bronchitis**
- ☐ **Emphysema**
- ☐ **TB**
- ☐ Any other chronic respiratory disorder
- ☐ Date of last chest x-ray _____

Cardiovascular
- ☐ **Chest pain or tightness**
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ **Heart attack**
- ☐ Swelling in ankles
- ☐ **High blood pressure**
- ☐ Pain in calves when walking
- ☐ Phlebitis
- ☐ Blood clots
- ☐ Any other disease or disorder of the heart or blood vessels
- ☐ Date of last EKG_____

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Frequent nausea/vomiting
- ☐ Vomiting of blood
- ☐ Abdominal pain
- ☐ Colic
- ☐ **Jaundice**
- ☐ Frequent Diarrhea
- ☐ Chronic constipation
- ☐ **Black, tarry stools**
- ☐ **Bloody stools**
- ☐ Change in bowel habits
- ☐ Hemorrhoids
- ☐ Rectal pain
- ☐ Hernia
- ☐ Recurrent indigestion
- ☐ **Ulcer**
- ☐ Pancreatitis
- ☐ **Hepatitis**
- ☐ Gallstones
- ☐ Any other disease or disorder of the stomach, intestines or liver

Genitourinary
- ☐ **Pus or blood in the urine**
- ☐ Trouble starting to urinate
- ☐ Frequency
- ☐ Frequent walking to urinate
- ☐ **Burning with urination**
- ☐ Incontinence
- ☐ Venereal disease
- ☐ Kidney stones
- ☐ **Kidney or bladder infections**
- ☐ **Kidney failure**

Men only:
- ☐ Impotence
- ☐ Prostate problems
- ☐ Abnormal discharge from penis
- ☐ Vasectomy

Women only:
- ☐ Abnormal Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Abnormal nipple discharge
- ☐ Painful intercourse
- ☐ Hysterectomy

If not hysterectomy, are currently having regular menstrual cycles?_____

If in menopause, or have had a hysterectomy, are you on hormone replacement therapy?_____

Could you be pregnant? _____

Date of last menstrual cycle _____

Skin
- ☐ Easy bruising
- ☐ Bleeding tendency
- ☐ Rash
- ☐ Itching
- ☐ Enlarged or painful lymph node
- ☐ Cyst
- ☐ Tumor
- ☐ Skin cancer
- ☐ Abnormal scarring
- ☐ Other disease or disorder of the skin

Endocrine
- ☐ **Sugar in the urine**
- ☐ Excessive urination
- ☐ Excessive hunger
- ☐ Excessive Thirst
- ☐ Temperature sensitivity
- ☐ **Diabetes**
- ☐ Hyper-thyroidism
- ☐ Hypo-thyroidism
- ☐ Abnormal hormone levels
- ☐ Other endocrine disorders

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Weakness in arms
- ☐ Weakness in legs
- ☐ Fractures
- ☐ Deformity
- ☐ Amputation
- ☐ Rheumatism
- ☐ Gout

Neurological
- ☐ Weakness
- ☐ Paralysis
- ☐ Atrophy
- ☐ Tremors
- ☐ Seizures
- ☐ Imbalance
- ☐ Numbness
- ☐ Tingling
- ☐ Transient ischemic attacks
- ☐ Stroke
- ☐ Multiple sclerosis
- ☐ Fibromyalgia

Mental status
- ☐ Problem with relationships
- ☐ Sudden mood changes
- ☐ Hallucinations
- ☐ Delusions
- ☐ Depression
- ☐ Insomnia
- ☐ Drug addiction
- ☐ Claustrophobic
- ☐ Other mental disorder

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

_____

Patient Signature & Date

_____

Please print your name

_____

I have reviewed the information provided by the patient. Physician Signature & Date

NEUROSPINE
SURGICAL CONSULTANTS

X-RAY CONSENT FORM

Patient: _____ Minor Yes No

Do you have a Spinal Cord Stimulator? Yes No

**If yes, please turn off your stimulator 5 minutes prior to x-ray

I consent to any diagnostic x-ray procedure(s) my medical provider may consider necessary or advisable in the course of my health care. I understand that diagnostic x-ray procedures may be ordered to be performed in accordance with my appointment today and they will be performed at Neurospine Surgical Consultants under the supervision of a registered Non-Certified Radiologic Technician. I understand the nature and purposes of these procedure(s) and the risks involved.

_____ Date: _____
Patient/Guardian Signature

FEMALE PATIENTS ONLY

I understand the physician has ordered an x-ray and I am giving permission to have the procedure(s) performed. I am aware radiation to the abdomen or pelvis can cause injury to a fetus.

Onset of last menstrual period: Date: _____ Today's Date: _____

I am verifying I:

- ☐ I am pregnant, _____ weeks
- ☐ May be pregnant

I believe I am NOT pregnant due to:

- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Use of birth control measures: _____
- ☐ Abstinence

By signing below, I attest the above statements are true. I hereby release Neurospine Surgical Consultants from liability for any adverse effects that may arise from undergoing diagnostic imaging at this time if I am subsequently found to have been pregnant and I assume responsibility for my decision to undergo this procedure.

_____ Date: _____
Patient/Guardian Signature

NEUROSPINE
SURGICAL CONSULTANTS

6160 Windhaven Pkwy
Suite 200 Plano, TX 75093
Phone # (972) 378-6908
Fax # (972) 378-6586

Dr. Luis Mignucci Dr. Omar Colon

Dear patients,

Please be aware that medications CANNOT be filled the same day you request them. When you call our office for refills the process may take up to 5 days to be completed. Plan accordingly and don't wait till the last minute.

If you are a patient of Dr. Colon, make sure you speak with him about your medication(s) at your office visit. Dr. Colon sees patients only on Wednesday afternoons.

We understand that pharmacies may have a shortage of medications. Please allow at least **5 business days** for our office to send requests to the new pharmacy.

Patient's Name _____

Provider Signature _____ Date _____

NEUROSPINE
SURGICAL CONSULTANTS

Medication Prescription and Refill Policy For
Luis A. Mignucci, M.D.
Omar A. Colon, M.D.

As a reminder to our patients, this is a surgical practice. Pain medications will be prescribed in the immediate post-operative period only. Use of pain medications beyond the immediate post-operative period will need to be managed by a pain management specialist.

Refill requests for medications prescribed by our office will be accepted **only from your pharmacy** during our regular business hours which are Monday thru Friday from 9am-4:30pm. If you need a refill on your medication, you must call the refill request into the pharmacy at which it was originally filled. **Do not call the office** directly as this will only delay the process. If your request is received after 2:00 pm Monday-Thursday, or after 12:00 pm on Friday, it will be processed the next business day. **Absolutely no refills will be authorized on Saturday or Sunday.**

I have read and understand the above policy.

Patient Name (Printed) _____

_____ _____
Patient Signature Date

Revised 06/05/2023

NEUROSPINE
SURGICAL CONSULTANTS

6160 Windhaven Parkway Suite 200 Plano, Texas 75093

Luis A. Mignucci, M.D.
Omar Colon, M.D.

Thank you for choosing NeuroSpine Surgical Consultants for your medical needs.

Your appointment for a surgical evaluation has been scheduled for:

_____

PLEASE READ CAREFULLY THE FOLLOWING INSTRUCTIONS:

- **Physician Referral**: Some insurance companies require a referral from a primary care physician (PCP). Please contact your insurance company or PCP to determine if you need a referral. If your insurance is one that requires a referral, please obtain the referral and provide it to our office. The referral **must** be on file before our medical personnel can see you. **PLEASE BRING YOUR MEDICAL INSURANCE CARD(s) AS WELL AS A PICTURE ID (Driver's License) TO YOUR APPOINTMENT.**

- **Medical History Form**: Please complete the enclosed medical history form as completely and accurately as possible. Please include the name, strength and dose of **all medications.** Your past medical and surgical history should be as accurate as possible. **HAVING THIS PAPERWORK COMPLETED PRIOR TO YOUR APPOINTMENT TIME WILL HELP AVOID DELAYS IN SEEING THE DOCTOR.**

- **Diagnostic CD'S: (X-rays, CT Scans, MRI CD'S, etc):** In order for the provider to properly evaluate and determine your diagnosis, it will be necessary to review your most recent diagnostic CD'S (Plain X-rays, CT Scans, MRI CD'S, etc). **PLEASE BRING THESE CD'S WITH YOU TO YOUR APPOINTMENT – YOU MUST HAVE THEM WITH YOU AT THE TIME OF YOUR APPOINTMENT OR YOUR APPOINTMENT WILL HAVE TO BE RESCHEDULED.** CD'S will not be accepted at our offices prior to your appointment time.

- **Medical Records/Office Notes:** It is also necessary for us to have your most recent medical records which relate to the condition necessitating this appointment. The last one or two office notes from your referring physician should be adequate.