NEW PATIENT REGISTRATION FORM

Name(Last, First, Initial)	Home Phone	Date of Birth	Cell Phone
Address	City	State	Zip
Social Security #	Referring Doctor	Marital Status ☐Single ☐Married ☐Divorced	Sex ☐Male ☐Female
Occupation	Employer	Employer Phone #	
Employer Address	City	State	Zip
Responsible Person	Emergency Contact Person	Emergency Contact Phone #	

PRIMARY INSURANCE INFORMATION

(Please provide a copy of your Insurance Card)

Insurance Name	Address		
Insured's Name	Subscriber #	Group #	Insurance Phone #
Insured's Date of Birth	Insured's Social Security #	Insured's Phone #	Sex ☐Male ☐Female
Insured's Address	City	State	Zip
Insured's Employer	Employer's Phone #		
Employer Address	City	State	Zip

INDUSTRIAL INSURANCE

Insurance Carrier Name			
Address	City	State	Zip
Adjuster's Name	Adjuster's Phone #	Claim #	
Date of Injury	Employer Name and Address		
Attorney's Name	Address		
Attorney's Phone #	Attorney's Fax #		

SECONDARY INSURANCE INFORMATION

(Please provide a copy of your Insurance Card)

Insurance Name	Address		
Insured's Name	Subscriber #	Group #	Insurance Phone #
Insured's Date of Birth	Insured's Social Security #	Insured's Phone #	Sex ☐Male ☐Female
Insured's Address	City	State	Zip
Insured's Employer	Employer's Phone #		
Employer Address	City	State	Zip

I authorize my physician to release any information to my insurance company or agency for services provided and reported. I also authorize payment of medical benefits to be directly to the physician provider for services rendered. I understand I am financially responsible for charges that are not covered by this authorization. I agree that a photographic copy of this authorization is as if such copy were the original.

_____ _____

Patient Signature Date

NEUROSURGERY
MEDICAL INFORMATION QUESTIONAIRE
Kapil Moza, MD

Please take some time to carefully fill out the following forms so that we may provide you with our very best of care.

Please tell us a little about yourself.

Last Name:	First:	Middle:
Birth Date: (mo/day/yyyy): _____	Age:_____ Weight:_____	Sex: Male ☐ Female ☐ Height:_____

Your Occupation(s)

Are you presently working? ☐ Disabled? ☐ Retired? ☐				
Marital Status:	☐ Married	☐ Single	☐ Divorced	☐ Separated ☐ Widowed
Do you have children?		☐ Yes	☐ No	If Yes, How many?_____

In your own words, please describe your problem and the reason for visiting us today?

Symptoms: Duration_____

Please tell us what treatments you have had received up to now for the problems you are describing above.

Treatment:	When/How Long?	Did it help?

NEUROSURGERY
MEDICAL INFORMATION QUESTIONAIRE
Kapil Moza, MD

Please tell us about any previous surgical procedures you have had in the past.

Previous Surgeries:	Dates:	Please describe Any Reactions? Yes☐	No☐

Please tell us about any other medical issue you may have. (Examples hypertension, diabetes, stroke, cancer, etc)

Medical issue?	How long?	Any Treatment?	When?

Do you Smoke?	☐Yes	☐No	How many packs per day?			For how many years?_____		
Do you Drink?	☐Yes	☐No	What do you drink?			How often_____		
Do you have Osteoporosis?	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No	Cancer	Yes☐	No☐
Recent infections?	☐Yes	☐No	HIV/AIDS	☐Yes	☐No	Hepatitis	Yes☐	No☐
Heart Attacks?	☐Yes	☐No	Chest Pain	☐Yes	☐No	Lung Issues	Yes☐	No☐

Please tell us about your family history. Parents, Grandparents, Siblings, (living, deceased, age of death and cause)

Father	Living_____	deceased_____	if deceased, age and cause_____
Mother	Living_____	deceased_____	if deceased, age and cause_____
Maternal Grandmother	Living_____	deceased_____	if deceased, age and cause_____
Paternal Grandmother	Living_____	deceased_____	if deceased, age and cause_____
Maternal Grandfather	Living_____	deceased_____	if deceased, age and cause_____
Paternal Grandfather	Living_____	deceased_____	if deceased, age and cause_____
Brother	Living_____	deceased_____	if deceased, age and cause_____
Sister	Living_____	deceased_____	if deceased, age and cause_____

Please tell us about ALL medications, pain pills, aspirins, or supplements you are taking or have recently taken.

Medication:	**Strength/Dosage:**

Please list all allergies to medications.

Allergies to medications:	All Other allergies:

Please list all recent X-Rays, CT's, MRI's, or other studies you have had for your current medical problem.(dates/location)

Studies:	Dates/Locations:

Are you claustrophobic to scans? ☐Yes No☐ Have you required sedation in the past? ☐Yes No☐

NEUROSURGERY
MEDICAL INFORMATION QUESTIONAIRE
Kapil Moza, MD

General Medical Review of Systems

Allergies
- ☐ Asthma
- ☐ Hay Fever
- ☐ Skin Eruption

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ High/low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose Veins

Constitutional
- ☐ Chills/Sweats/Fever
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Nervousness
- ☐ Weight loss

Ears, Nose, Mouth & Throat
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Ear ache
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Persistent cough
- ☐ Ringing in the ears
- ☐ Sinus problems

Endocrine
- ☐ Rapid weight loss/gain
- ☐ Intolerance to a warm room
- ☐ Multiple broken bones
- ☐ Cessation of menstrual period
- ☐ Excessive hunger/thirst
- ☐ Loss of libido
- ☐ Spontaneous nipple discharge

Eyes
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Vision flashes or halos

Genitourinary
- ☐ Blood in the urine
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor appetite
- ☐ Rectal Bleeding
- ☐ Stomach/Abdominal Pain

Hematologic/Lymphatic
- ☐ Swollen lymph nodes
- ☐ Easy skin bruising
- ☐ Prolonged bleeding

Integumentary
- ☐ Skin Rashes or Skin eruptions
- ☐ Chronic skin itching

Men:
- ☐ Breast lump
- ☐ Lump in testicle
- ☐ Penis discharge
- ☐ Sore on penis

Musculoskeletal

Do you experience any of the following?
- ☐ Pain, weakness, numbness, swelling in,
- ☐ Hands
- ☐ Wrists
- ☐ Hips
- ☐ Knees or joints
- ☐ Arms or legs

Neurological
- ☐ Fainting
- ☐ Headache
- ☐ Numbness

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Restlessness

Respiratory
- ☐ Blood
- ☐ Cough
- ☐ Dizziness
- ☐ Shortness of breath

Women:
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot Flashes
- ☐ Nipple discharge
- ☐ Painful intercourse

Last Menstrual Period_____
Last Pap smear_____
Last mammogram_____
Are you pregnant?_____
No. of Children_____
Ages:_____
_____
_____
_____
_____
_____
_____

NEUROSURGERY

MEDICAL INFORMATION QUESTIONAIRE

Kapil Moza, MD

Please list referring physician(s) or other physician(s) whom are involved in your medical care.

Physician's Name:______________________________

Specialty: ______________________________

Address: ______________________________

____

____

Phone Number: ______________ Fax Number______________

Physician's Name:______________________________

Specialty: ______________________________

Address: ______________________________

____

____

Phone Number: ______________ Fax Number______________

Physician's Name:______________________________

Specialty: ______________________________

Address: ______________________________

____

____

Phone Number: ______________ Fax Number______________

Physician's Name:______________________________

Specialty: ______________________________

Address: ______________________________

____

____

Phone Number: ______________ Fax Number______________

Neurosurgery
Kapil Moza, MD

Notice of Privacy Practices
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy of Practices. Our Notice of Privacy Practices provides information about how we may use and disclose health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our "Notice", you may obtain a copy of the revised "Notice" by contacting our office at (805) 497-3636.

If you have any questions about our Privacy Practices, do not hesitate to contact our office.

I acknowledge receipt of the Notice of the Privacy Practices

Patient Name:_____ DOB: _____

Patient Signature:_____ Date: _____

Relationship to Patient:_____

Protected Health Information (PHI) Disclosure Record

In general, the HIPPA privacy rules give an individual the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications of PHI is made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner:

Home Phone_____

Cell Phone_____

Work Phone_____

Check all that apply: ☐ Leave call back number only ☐ OK to leave message with call back number.
☐ OK to leave detailed message with person answering the phone

For written correspondence: ☐ Mail/Delivery service only
☐ Fax Message – Fax number_____