Matthew R. Stanfield M.D.

Neurosurgeon

New Patient Intake Form

I. Identifying Demographic and Social Information

Name: (First)_____ (Middle) _____ (Last) _____

Birth/Maiden Name:_____ Date of Birth _____/_____/_____ Gender: ❑ Male or ❑ Female

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

Social Security Number: _____ Occupation: ❑ Employed ❑ Retired ❑ Student

Driver License Number: _____ License Expires: _____ State: _____

Street Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Patient Employer: _____

Employer Address: _____
Street City State Zip

Emergency Contact Name: _____ Relationship to Patient: _____ Phone: _____

Language: ❑ English or ❑ Other: _____ Race: _____ Religion: _____

II. If Patient is a Minor, Responsible Party (If applicable)

Name: _____ Occupation: _____

Social Security Number: _____ Phone: _____

Street Address: _____
Street City State Zip

Employer: _____ Employer phone: _____

Employer Address: _____
Street City State Zip

Is this visit related to worker's compensation? ❑ Yes ❑ No

Is this visit related to any legal actions? ❑ Yes ❑ No

If this problem is the result of an accident, when did the accident occur? _____

Name: _____

III. Primary Health Insurance Policy Information

Health Insurance Company: _____

Insured Policy Identification Number: _____ Group Number: _____

Policy Holder Name/Subscriber Name: _____

Relationship to Insured: ❑ Yourself ❑ Spouse ❑ Parent ❑ Other: _____

(If you checked that the policy holder/subscriber relationship to Insured is someone other than yourself please provide the following)

Policy Holder/Subscriber Social Security Number: _____

Policy Holder/Subscriber Employer: _____ Policy Holder/Subscriber Date of Birth _____/_____/_____

IV. Secondary Health Insurance Policy Information (If applicable)

Health Insurance Company (Secondary):_____

Insured Policy Identification Number: _____ Group Number: _____

Policy Holder/Subscriber: _____ Social Security Number: _____

Relationship to Insured: ❑ Yourself ❑ Spouse ❑ Parent ❑ Other: _____

(If you checked that the policy holder/subscriber relationship to Insured is someone other than yourself please provide the following)

Policy Holder/Subscriber Employer: _____ Policy Holder/Subscriber Date of Birth _____/_____/_____

HIPPA) I authorize practice/billing company to contact me about my bill reaching me via*: (If all boxes are checked "no" we will require prepayment on all services)* **Phone: ❑ Yes ❑ No Cell phone: ❑ Yes ❑ No Work phone: ❑ Yes ❑ No Mail: ❑ Yes ❑ No**

Benefits to Physician: I hereby authorize payments directly to Matthew Stanfield, M.D. of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract.

Signed (Patient or Parent of Minor): _____

Release of Information: I hereby authorize release of information necessary for filing my insurance claim or filing a payment review.

Signed (Patient or Parent of Minor): _____

I have received a Notice of Privacy Practices from the office of Matthew Stanfield, M.D.

Signed: _____ Date: _____

I have signed the patient consent for use and disclosure of protected health information from the office of Matthew Stanfield, M.D.

Signed: _____ Date: _____

You may speak with the following person(s) about my bill regarding medical services provided:

Name: _____ Relationship: _____ Phone: _____

You may not speak with the following person(s) about my bill regarding medical services provided:

Name: _____ Relationship: _____

Name: _____

V. Physician Care Information (Please provide First and Last names)

Primary Care Physician: _____

Referring Physician (if different from PCP): _____Specialty*: _____

Other Physician: _____Specialty*: _____

Other Physician: _____Specialty*: _____

*Specialty examples: Lung= Pulmonologist, Heart=Cardiologist, Nerves=Neurologist, Endocrinologist=Hormones/Glands, Urologist=Urinary, Orthopedic=Muscle/Skeletal, etc.

Pharmacy:_____ Pharmacy Location: _____

VI. Reason for Visit – Chief Complaint (History of Present Illness)

Please describe the major problem that brings you in today to see a Neurosurgeon:

_____

_____

VII. Family History Do you have a family member affected with :

Condition	Yes	No	type /affected relative	Condition	Yes	No	type /affected relative
Cancer (Non Brain)	❑	❑		Bleeding/Clotting	❑	❑	
Glioma	❑	❑		Heart Disease	❑	❑	
Meningioma	❑	❑		High Cholesterol	❑	❑	
Brain Aneurysm	❑	❑		Hypertension	❑	❑	
Other Aneurysms	❑	❑		Diabetes	❑	❑	
Other Conditions	❑	❑					

Write other conditions: _____

VIII. Pain Assessment

Do you experience pain as a part of your daily life? ❑ Yes ❑ No

If yes, please describe the location(s), onset, duration, and characteristics of your pain:

_____

_____

_____

If yes, on a scale of 1 to 10 (0=no pain, 10=the worst pain), how would you rate your pain? _____

Name: _____

IX. Surgical History Please list all operations you have had: Date:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

X. Medical History Please list all medical conditions: Duration:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list all **MEDICATIONS** you take routinely, prescribed or over the counter, along with dosages:

Medication: Dose: Frequency:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you **ALLERGIC** to any medicines, latex, X-ray dye, or iodine? ❑ Yes ❑ No

If yes, please explain: _____

Are you taking any "blood thinning" medications? ❑ Yes – indicate below ❑ No

Aspirin or aspirin-containing medication ❑ Anti-inflammatory medicine ❑ Plavix ❑

Coumadin ❑ Fish Oil ❑ Other: _____

Name: _____

XI. Social Information and History (Continued)

Education Completed: _____ Number of Children: _____

Do you Smoke cigarettes? ❑ Yes ❑ No If yes, how many packs a day? _____

If yes, at what age did you start smoking? _____ If applicable, at what age did you stop? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much daily? _____

If yes, at what age did you start drinking? _____ If applicable, at what age did you stop? _____

Do you use recreational drugs? ❑ Yes ❑ No If so, what type of drug(s)? _____

Do you exercise regularly? ❑ Yes ❑ No How frequently? _____

Females: Are you, or could you be pregnant? ❑ Yes ❑ No

Age at last menstrual period? _____ Have you ever used Oral Contraceptives? ❑ Yes ❑ No

Have you ever used Hormone Replacement Therapy? ❑ Yes ❑ No

XII. Health Care Proxy?

Do you have a Health Care Proxy? (check one) ❑ **Yes** ❑ **No**

If yes, please list: _____

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

_____ _____

Patient Signature Date completed

Revised February 20, 2014

Name: _____

XIII. Review of Symptoms In the past 6 months have you had a problem with:

Constitutional:	***Yes***
Fever	❑
Weight loss	❑
Excessive fatigue	❑
History of Falls	❑
Eyes:	
Wear glasses	❑
Infections	❑
Injuries	❑
Glaucoma	❑
Cataracts	❑
Ear, Nose, Throat & Mouth:	
Wear hearing aids(s)	❑
Hearing loss	❑
Ear pain/infections	❑
Ringing in ears	❑
Nose bleeds	❑
Nasal congestion/drainage	❑
Inability to smell	❑
Sinus problems	❑
Balance (vertigo,spinning,etc.)	❑
Cardiovascular:	
Chest pain or angina	❑
High blood pressure	❑
Irregular pulse	❑
Heart murmur	❑
High cholesterol	❑
Swelling in hands or feet	❑
Leg pain while walking	❑
Respiratory:	
Asthma	❑
Emphysema	❑
Shortness of breath	❑
Pneumonia	❑
Bloody sputum	❑
Gastrointestinal:	
Nausea	❑
Vomiting	❑
Blood in your vomit	❑
Liver disease	❑
Jaundice	❑
Abdominal pain	❑
Change in bowel habits	❑
Ulcers or gastritis	❑

Endocrine:	***Yes***
Diabetes	❑
Thyroid disease	❑
Excessive thirst/urination	❑
Genitourinary:	
Urinary tract infections	❑
Painful urination	❑
Blood in your urine	❑
Difficult start/stop stream	❑
Incontinence	❑
Kidney stones	❑
Musculoskeletal:	
Broken bones	❑
Arm or leg weakness	❑
Arm or leg pain	❑
Joint pain or swelling	❑
Arthritis	❑
Integumentary:	
Skin disease	❑
Breast pain or tenderness	❑
Neurological:	
Fainting Spells or “black outs”	❑
Seizures	❑
Problems with memory	❑
Disorientation	❑
Difficulty with speech	❑
Inability to concentrate	❑
Double or blurred vision	❑
Weakness in arms and/or legs	❑
Loss of sensation	❑
Difficulty with balance	❑
Psychiatric:	
Anxiety	❑
Depression	❑
Hematologic/Lymphatic:	
Anemia	❑
Hemophilia	❑
Bleeding tendencies	❑
Blood transfusion	❑
Swollen glands/lymph nodes	❑
HIV	❑
Allergic/Immunologic:	
Food, Inhalant, nasal allergies	❑
Autoimmune disease	❑

Matthew R. Stanfield, M.D.

Neurological Surgery

Please fill out the enclosed paper work and bring it with you to your appointment.

Please bring a COPY (disk or films) of all your X-Rays/MRIs/CTs with you on the day of your appointment.

If you do not bring a COPY of all your imaging, we will have to reschedule your appointment.

Due to the complexity of neurosurgery, our scheduled appointments may run over the allotted time depending on your individual diagnosis. Please understand if your appointment has been delayed that you will receive the same high standard of patient care as the person before you.

Dr. Stanfield is a practicing physician at Deaconess Hospital and is always on call for emergencies. Therefore your appointment may be delayed or rescheduled. You are invited to bring a book, crossword, etc.

Our Office has handicap parking spaces available for our patients regardless of disability.

If you are unable to make your scheduled appointment please call to cancel or reschedule as soon as possible. This will allow us to schedule another patient who is in pain and needing to see Dr. Stanfield.

We thank you in advance for your patience.

Thank you,

Dr. Matthew Stanfield's Office

5500 North Portland Avenue, Oklahoma City, Oklahoma 73112

Office: (405) 949-1800 Fax: (405) 949-1801

SPINAL CONCERNS INTAKE FORM

Name _____

Date _____

It is understood that the following questions are not all easily answered. Please do not feel obligated to answer these if anything doesn't clearly fit or make sense with respect to your unique condition.

Please circle all that apply. If you have more than one concern, try to answer based on the one you feel is most concerning or limiting.

How did the concern(s) begin?

- Gradually
- All at once
- In association with a specific event
- Difficult to answer or not sure

When did the concern(s) begin?

- _____Years ago
- _____Months ago
- _____Weeks ago
- _____Days ago
- Hours ago
- Difficult to answer or not sure
- In some ways recently, and in others a long time ago
    - If this answer fits best, please still try to circle another option also as best as you can. Remember, try to focus on concern you find the most limiting or concerning.

Treatment efforts so far? Things you've tried?

Yes	No	**Non-Steroidal, Anti-Inflammatory Drugs (NSAIDS)** - Examples: ibuprofen (Motrin, Advil), aspirin, naproxen (Naprosyn, Aleve), meloxicam (Mobic), Relafen, ketoprofen, Celebrex, Toradol, Voltaren, etc.
Yes	No	**Physical Therapy** How many visits _____ Over how much time _____
Yes	No	**Chiropractic or Osteopathic treatments/adjustments**
Yes	No	**Acupuncture**
Yes	No	**Oral Steroids** - Examples: prednisone, Medrol Dose Pak, hydrocortisone
Yes	No	**Steroid injection(s)** How many? _____
Yes	No	**Other injections/pain specialist techniques** - Examples: trigger point injections, facet injections, radio frequency ablations, spinal cord stimulator, etc.
Yes	No	**Opiods** - Examples: "true pain pills", hydrocodone (Lortab, Vicodin, Norco), oxycodone (Percocet, Oxycontin), codeine (Tyelenol#3), tramadol (Ultram), morphine (MS Contin) certain patches, Suboxone, hydromorphone (Dilaudid), meperidine (Demerol), fentanyl, methadone etc.
Yes	No	**Currently still have to take opioids at least on occasion?** - If so, how many tablets and of what kind: - On a good day? _____ - On a bad day? _____

Yes	No	**Neuropathic pain meds** - Examples: gabapentin (Neurontin), Lyrica, amitriptyline (Elavil), diazepam (Valium), alprazolam (Xanax), lorazepam (Ativan), Cymbalta, other anti-seizure meds/psych meds
Yes	No	**Muscle relaxants** - Examples: methocarbamol (Robaxin), cyclobenzaprine (Flexeril), baclofen, Soma, Norflex, diazepam (valium), Parafon Forte, Skelaxin, tizanidine (Zanaflex) etc.
Yes	No	**Heat/Heating pad**
Yes	No	**Massage**
Yes	No	**Topical Creams** - Examples: Icy Hot, Bengay etc.
Yes	No	**Tens units, neuromuscular stimulators (muscle stimulators), other electronics**
Yes	No	**Other (s)** _____