Jerry V. Marlin, M.D., P.A.
Neurological Surgery
8220 Walnut Hill, Suite 604
Dallas, Texas 75231
(214)363-2587
FAX (214)363-6996
Web Site: http://DRJERRYMARLIN.com

Patient name: _____

You have been scheduled for an appointment to see Dr. Jerry Marlin on: _____

Please fill out the attached new patient forms and bring them with you along with your insurance card.

It is also your responsibility to arrange to pick up any and all MRI, CT or X-ray films and the written radiology reports. Contact the facility where you had the exam done and arrange to pick them up.

IF YOU DO NOT BRING YOUR FILMS AND REPORTS WITH YOU, YOUR APPOINTMENT MAY BE RESCHEDULED.

Our office is located at 8220 Walnut Hill Lane, Professional Bldg. 2 Suite 604 Dallas, TX 75231 (at Presbyterian Hospital of Dallas). Our office phone is (214) 363-2587.

If you are unable to keep this appointment please call at least 24 hours prior to cancel or reschedule.

NEW PATIENT INFORMATION

DR. JERRY V. MARLIN, M.D., P.A.

(Please print)

NAME: _____ TODAY'S DATE _____
Last First Middle Initial

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME # ( ) _____ - _____ CELL # ( ) _____- _____ MARITAL STATUS: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ DRIVER'S LICENSE NUMBER _____
WHO IS THE REFERRING PHYSICIAN? _____

EMPLOYER: _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

BUSINESS PHONE: ( ) _____ - _____ OCCUPATION _____

HOW LONG HAVE YOU BEEN EMPLOYED WITH THIS COMPANY? _____

Are you currently a STUDENT Yes _____ No _____

IN CASE OF EMERGENCY CONTACT

NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
RELATIONSHIP _____

Emergency Contact Telephone: ( ) _____ - _____
IF MARRIED, THE NAME OF YOUR SPOUSE _____

SPOUSE'S PHONE NUMBER: ( ) _____ - _____ SPOUSE'S SOCIAL SECURITY NUMBER _____ - _____ - _____

SPOUSE'S DATE OF BIRTH _____ - _____ - _____ SPOUSE'S EMPLOYER _____

HEALTH INSURANCE INFORMATION

NAME OF YOUR PRIMARY INSURANCE COMPANY _____

ADDRESS OF INS. CO. _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER: ( ) _____ - _____

POLICY OR ID NUMBER _____ GROUP NUMBER _____

NAME OF POLICY HOLDER _____ RELATIONSHIP _____

DO YOU HAVE A SECONDARY INSURANCE POLICY? Yes _____ No _____

NAME OF YOUR SECONDARY INSURANCE COMPANY _____

ADDRESS OF INS. CO. _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER: ( ) _____ - _____

POLICY OR ID NUMBER _____ GROUP NUMBER _____

NAME OF POLICY HOLDER _____ RELATIONSHIP _____

IS YOUR PRESENT CONDITION THE RESULT OF AN AUTOMOBILE ACCIDENT? Yes _____ No _____

DATE OF ACCIDENT: _____ - _____ - _____

WORKER'S COMPENSATION INFORMATION

IS YOUR PRESENT CONDITION THE RESULT OF AN ON-THE-JOB INJURY? Yes ___ No ___ DATE OF INJURY: _____

DO YOU HAVE WORKER'S COMPENSATION INSURANCE COVERAGE? Yes _____ No _____

NAME OF YOUR INSURANCE CARRIER _____ CLAIM NUMBER _____

ADDRESS OF INS. CO. _____ CITY _____ STATE _____ ZIP CODE _____

NAME OF YOUR ADJUSTER: _____ ADJUSTER'S PHONE #: _____

(PLEASE READ AND SIGN)

ALL PROFESSIONAL SERVICES RENDERED BY DR. JERRY V. MARLIN, M.D., P.A. ARE CHARGED TO THE PATIENT. NECESSARY PAPER AND ELECTRONIC FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN **MADE IN ADVANCE**.

Photographs will be taken during your visits and placed in your medical chart including surgical photographs.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE DR. JERRY V. MARLIN, M.D., P.A. TO FURNISH ALL INFORMATION TO MY INSURANCE CARRIER OR OTHER TREATING PHYSICIANS CONCERNING MY ILLNESS AND TREATMENT. I HEREBY ASSIGN TO DR. JERRY V. MARLIN, M.D., P.A., THE PHYSICIAN, ALL PAYMENTS FOR MEDICAL AND/OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. A PHOTOCOPY OR SCANNED COPY OF THIS ASSIGNMENT IS TO BE VALID AS THE ORIGINAL.

SIGNATURE OF PATIENT _____ **DATE** _____

PATIENT CONSENT FORM

I understand that as part of my healthcare, _____ ("PHYSICIAN") 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 is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The PHYSICIAN's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that the PHYSICIAN reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

☐ I request the following restrictions on the use and/or disclosure of my personal health information.

_____

_____

_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the PHYSICIAN's *Notice of Privacy Practices* dated _____.

_____ _____

Signature of Patient or Legal Representative Date

_____

Print Name of Patient or Legal Representative

*I request that changes to the *Notice of Privacy Practices* be sent to me at this address: _____

_____

NAME: _____ DATE: _____

MEDICATIONS AND ALLERGIES:

Please list accurately your current prescription medications and dosage and time taken. (Include over the counter drugs and herbal medications.)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

PLEASE LIST ALLERGIES TO MEDICATIONS OR FOODS:

_____

_____

_____

Have you had any blood transfusions? Yes ____ No ____ When: _____

Do you smoke: Yes ____ No ____ If yes, how many packs per day? ____ For how many years? ____

Do you drink alcohol? Yes ____ No ____ If yes, how much? Daily? _____ Weekly? _____

COLONOSCOPY: When? _____ Results: Normal? Yes _____ No _____

MAMMOGRAM: When? _____ Results: Normal? Yes _____ No _____

PAP SMEAR: When?_____ Results: Normal? Yes _____ No _____

PROSTATE EXAM: When?_____ Results: Normal? Yes _____ No _____

PSA? Result? _____

Name:_____ **Date:** _____

PAST MEDICAL HISTORY:

Who is your **Primary Care Physician**?_____

Please list any surgical procedures and the name of the hospital used, and surgeon and the date of the operation:

1._____

2._____

3._____

4._____

5. _____

6._____

7._____

Did you have any problems with the anesthesia used during the surgery or anesthetic medications? Yes ____ No ____ Please offer details of the problem(s): _____

_____

Name:_____ Date: _____

PAST MEDICAL HISTORY:

Please list any Medical Illness or Medical diagnosis or Health Care problem:

1._____

2._____

3._____

4._____

5._____

6. _____

Are you Pregnant: Not/Applicable____ Yes___ No___

Have you been diagnosed with or have you had any of the following conditions?

High blood pressure Yes ___ No ___ Diabetes Yes ___ No ___

Liver Disease or Hepatitis Yes ___ No___ Renal Disease: Yes ___ No__

Heart Disorders such as a heart attack or cardiac arrhythmia? Yes ___ No ___

Stroke: Yes ___ No___ Seizure: Yes ___ No ___

Urinary Tract Infections Yes ___ No___ Stomach Ulcers :Yes ___ No ___

Lung Disorders: Yes ____ No____ Asthma or wheezing: Yes ___No __
Arthritis : Yes ___ No ___

Thyroid Disorder: Yes___ No___ History of Tuberculosis Yes____ No___

History of positive test for HIV or History of AIDS: Yes___ No____

Name:_____ **Date:** _____

MEDICAL HISTORY

Do you have indigestion currently? Yes ___ No ___ Weight loss? Yes___ No___

Do you have any problems with nausea or vomiting currently? Yes ____ No ___

Have you recently notice any blood in your stool or urine? Yes_____ No____When?_____

Do you have any bleeding Tendency Yes____ No ___ Or Nose bleeds Yes____ No___

Do you have any bleeding when you brush your teeth? Yes ___ No___

Are you shortness of breath? Yes____No____ or Coughing? Yes___ No__

Are you having problems with chest pain recently or in the past? Yes____No____

Do you have problems with your vision Yes ____ No _____

or double vision or blurred vision? Yes____ No____

Do you have problems with your vision such need for reading glasses? Yes____ No____

Have you had any recent infections? Yes____ No ____ or Fever? Yes____ No____

Have you had problems with swallowing? Yes____ No _____

Sore throat? Yes____ No ____ Or Earaches? Yes____ No _____

Do you have headaches? Yes____ No____ How often do you have headaches?_____

Do you have problems with your hearing? Yes ____ No _____

Do you have problems with dizziness? Yes ____ No___

Do you have any metal in your body? Yes____ No____ or implanted devices(such as a pacemaker) Yes____ No____

Do you have dentures? Yes ____ No _____

Do you have any problems with depression? Yes___ No___

or Memory loss Yes____ No____

Do you have a history of sleep apnea? Yes_____ No _____ Do you snore at night? Yes ____ No _____

Do you have a history of stopping breathing at night? Yes_____ No ____

Do you use a CPAP or breathing machine at night? Yes ___ No ____

Name:_____ Date: _____

SOCIAL HISTORY:

Are You Married: Yes___ No___

If married, please write your spouse's name:_____

Do you have a living will or have you assigned someone your durable power of medical attorney? Yes___ No__ Whom?_____

Children: Yes___ No____ How many?____ Grandchildren: Yes ___ No___

Please list at least one family member to contact in an emergency:

Name: _____Address:_____
Phone: _____

EDUCATION: Did you complete High school? Yes ___ No ___ College?: Yes__No___

Name of School: _____ Major:_____

EMPLOYMENT HISTORY:

What is your current employment position or title: _____

Are you currently employed? Yes____ No____
Brief description of your work:_____

Name of company:_____Telephone:(_____)_____

FAMILY HISTORY

Is your Mother living: Yes ___ No___
If deceased, age and cause of death :_____
Is your Father living: Yes ___ No ___
If deceased, age and cause of death: _____

Are there any diseases prevalent in your family? Yes ___ No ____
Please list any relatives who may have similar conditions like yours or specific diseases that may run in your family:

Maternal_____

Paternal_____