

# SOUTH SHORE NEUROSPINE GROUP, LLC



Stephen H. Johnson, MD, FACS

Katharine Bills Woods, PA-C

780 Main Street  
South Weymouth MA 02190  
781-331-0250/F 781-340-0506

[www.ssneuro.com](http://www.ssneuro.com)

Dear Patient:

Welcome to South Shore NeuroSpine Group, LLC. Please bring the following with you to your appointment:

- Insurance cards – Primary and/or Secondary Insurances.
- Co-payment. We accept cash, check, Visa, MasterCard and debit cards.
- MRI films or other imaging studies. **Please bring FILMS only – we cannot read disks (CDs).**
- Completed Medical History form and Registration form. Please visit our website for all forms.
- Worker's Compensation insurance information if applicable.
- Personal Injury Protection (PIP) exhaust letter if applicable.
- Photo ID.

**It is very important that you bring your MRI films to this appointment.** If you DO NOT have your MRI films, please call the facility where you had your MRI performed and make arrangements to pick up the films **PRIOR** to your visit. **If you had your MRI films sent to our office, please call to confirm that we have received them.** If you do not have your MRI films at the time of your appointment you will have to reschedule to another day. **If you had your MRI or other imaging studies performed at South Shore Hospital, you DO NOT need to bring the films to the office as we have access to these studies through the hospital electronic medical records system.**

Please call your Primary Care Physician to obtain an **INSURANCE REFERRAL** if needed to comply with your insurance plan.

If you need to reschedule or cancel your appointment, please call within 48 hours so that others may benefit from this appointment.

We look forward to providing your medical care. If you have any questions, please call our office.

Sincerely,  
South Shore NeuroSpine Group, LLC

DIRECTIONS:      *From the South:*      Travel North on Route 3 to Exit 16 – Route 18 South.  
Go through two traffic lights.  
Just after the second light, turn left into the parking lot  
at the South Shore Hospital Out Patient Services building.  
Our office is on the Lower Level, at the end on the right.

*From the North:*      Travel South on Route 3 to Exit 16B – Route 18 South.  
Go through two traffic lights.  
Just after the second light, turn left into the parking lot  
at the South Shore Hospital Out Patient Services building.  
Our office is on the Lower Level, at the end on the right.

**SOUTH SHORE NEUROSPINE GROUP, LLC**

Patient Medical History - Please Complete This Form Accurately As It Will Become Part Of Your Medical Record

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Your job description \_\_\_\_\_

Are you currently working (circle)? YES NO Stopped working on: \_\_\_\_\_

Have you ever had heart surgery (circle)? YES Date: \_\_\_\_\_ NO

Are you taking a blood thinner (circle)? YES Name of drug: \_\_\_\_\_ NO

Have you ever had spinal or brain surgery (circle)? YES NO

If yes please list date(s), type(s) of surgery, and surgeon's name.

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had anesthesia (circle)? YES NO Anesthesia complications? YES NO

Allergies (Medications or Dyes): \_\_\_\_\_

Medications (With Doses): \_\_\_\_\_

\_\_\_\_\_  
Pharmacy Name and Phone: \_\_\_\_\_

Are you being treated for any of the following? Check all that apply.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Seizure Disorder             | <input type="checkbox"/> Heart Disease          |
| <input type="checkbox"/> AIDS            | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Recreational Drug Use  |
| <input type="checkbox"/> Alcoholism      | <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Cancer - Type _____    |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Gastric Reflux               | <input type="checkbox"/> Hepatitis - Type _____ |
| <input type="checkbox"/> Brain Tumor     | <input type="checkbox"/> Aneurysm of Brain or Abdomen | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Migraine Headaches           | <input type="checkbox"/> Lung Disease           |
| <input type="checkbox"/> Night Sweats    | <input type="checkbox"/> Other _____                  | <input type="checkbox"/> CPAP                   |

Please estimate your: Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you recently experienced any of the following?:

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Fever      | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bowel/Bladder Problems | <input type="checkbox"/> Weight Loss        |

Do you smoke cigarettes? \_\_\_\_\_ Did you ever? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink alcohol, beer or wine (circle)? YES NO Daily Weekly Occasionally

Does anyone in your immediate family have any of the following problems? Please identify family member relationship.

- |              |                      |
|--------------|----------------------|
| Cancer _____ | Diabetes _____       |
| Stroke _____ | Heart Disease _____  |
|              | Spine Problems _____ |

Patient Signature: \_\_\_\_\_

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FIRST NAME: \_\_\_\_\_ M.I. \_\_\_\_ LAST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY OR TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE HOME: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

GENDER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

-----  
PRIMARY INSURANCE: \_\_\_\_\_ POLICY ID: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_ COPAY: \_\_\_\_\_

-----  
SECONDARY INSURANCE: \_\_\_\_\_ POLICY ID: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_ COPAY: \_\_\_\_\_

WORKERS COMPENSATION

AUTO ACCIDENT

If work related or related to an auto accident, you will be given another form to fill out.

## IMPORTANT REFERRAL NOTICE

*If you have health insurance that requires referrals from your primary care physician for services by a specialist, it is your responsibility to provide this office with a referral for all services.*

**I authorize the release of all medical information necessary to process insurance claims for my services.**

**I also authorize payment of medical benefits directly to South Shore NeuroSpine Group, LLC.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name