

SOUTH SHORE NEUROSPINE GROUP, LLC



Stephen H. Johnson, MD, FACS
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780 Main Street
South Weymouth MA 02190
781-331-0250/F 781-340-0506

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/CDs or other imaging studies. You can bring either MRI films or CDs with MRI images.
- 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/CDs to this appointment. If you DO NOT have your MRI films/CDs, please call the facility where you had your MRI performed and make arrangements to pick up the films/CDs **PRIOR** to your visit. **If you had your MRI films/CDs sent to our office, please call to confirm that we have received them.** If you do not have your MRI films/CDs 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/CDs to the office as we have access to these studies through the hospital electronic medical records system.**

Please call your Primary Care Provider 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 Hospital

Brigham and Women's Hospital

Cranial Surgery

· Minimally Invasive Surgery

· Complex Spine Surgery

· Peripheral Nerve Surgery

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: _____ Date: _____ MD/PA: _____ Date: _____

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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 PROVIDER: _____

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 provider 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