Welcome To Our Practice!

Raymond I. Haroun, M.D.
Megan Sisbarro, PA-C

The following information is very important to your health. Please take time to fully and completely fill out this information.

First Name: _____ Middle Name _____ Last Name _____
Social Security Number: _____ Sex: M F

Address: _____ Date of Birth: _____ Age: _____
City, State ZIP _____ Marital Status: S M W D Spouse's name: _____
Telephone: Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Relationship: _____
Emergency Contact phone numbers: _____

Who referred you to our office? _____ Phone #: _____
Primary Care Physician: _____ Phone #: _____

Please list all other physicians you would like us to send a report to:

1. Name _____
   Phone number: _____
2. Name: _____
   Phone number: _____
3. Name: _____
   Phone number: _____
4. Name: _____
   Phone number: _____

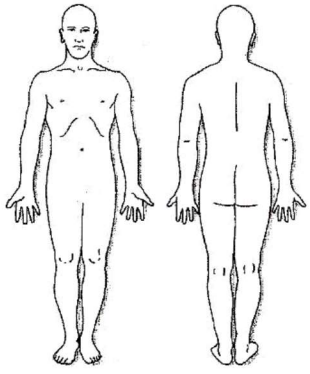
Reason for seeing the doctor today: _____
_____

Date Problem Began: _____ Is this work-related? **Y N** Is this related to an automobile accident? **Y N**

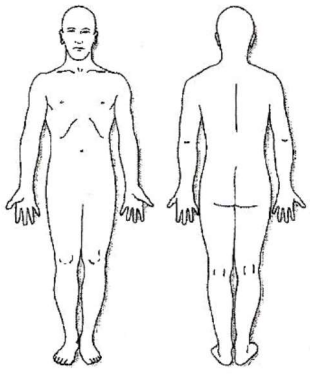
Please be as detailed as possible with your answers to the following:

What, if anything, triggered the problem? _____
What part of your body is affected? Right, Left, Both, _____
Describe your symptoms (numbness, sharp pain, tingling, stabbing)? _____
Have you experienced any weakness, clumsiness, or difficulty walking? _____
On a 0 to 10 scale, with 10 being the worst, how severe is the pain? _____
How do the symptoms interfere with your daily activities, (Preparing meals, dressing, walking, hobbies, etc.)?
_____
Where do your symptoms radiate (neck, arm, hand, shoulder, thigh, calf, ankle, foot, etc.) _____
What makes your symptoms better? _____
What makes your symptoms worse? _____
Do you have a history of chronic neck pain? **Y N** For how long? _____ A history of chronic back pain? **Y N** For how long? _____

In the diagram, below darken the areas where you initially began having symptoms.



In the diagram below, darken the areas where you are currently experiencing symptoms.



Please list ***all*** treatments you have undergone for this condition:

- Medications (name, dose, length of use) _____
- Injections (location, number, dates) _____
- PT, Chiropractic care (start & end date) _____
- Assistive devices (type & date started using) _____
- Others _____

Have you been treated by any other physicians, therapists, etc., regarding this condition? Yes / No

1. Doctor's name _____ Specialty _____
What treatments / Recommendations _____ Date of last visit _____
2. Doctor's name _____ Specialty _____
What treatments / Recommendations _____ Date of last visit _____

Have you had any diagnostic studies (*Please circle*)? MRI CT EMG Myelogram Other:_____

Medical History

Do you have any of the following health conditions? (*Circle Y or N for all)* High Blood Pressure **Y/N**

High Cholesterol	**Y/N**	Diabetes	**Y/N**	Heart attack/Heart Disease	Y/**N**	Lung Disease	**Y/N**	Cancer	Y/**N**
Bleeding Disorder	**Y/N**	Sleep Apnea	**Y/N**	Ulcers/Acid Reflux	**Y/N**	Thyroid Disease	**Y/N**	Stroke	**Y/N**
Blood Clots	**Y/N**	Seizures	**Y/N**	Rheumatoid Arthritis	**Y/N**	Depression	**Y/N**	HIV	**Y/N**
Hepatitis	**Y/N**	Glaucoma	**Y/N**	Kidney Disease	**Y/N**	Anemia	**Y/N**		

Do you have any other medical problems? Y/N (*Please List)* _____
Have you ever had a blood transfusion? **Y/N When? _____**

Current Medications/Herbal Supplements/Alternative Medications

Name of medication:	Reason for taking:	Name of medication:	Reason for taking:
1._____	_____	4._____	_____
2._____	_____	5._____	_____
3._____	_____	6._____	_____

Do you have any **medication allergies**: **Y/N** If yes, please list:_____
Reaction:_____
Are you allergic to: *Iodine* **Y/N** *Latex* **Y/N** *Shellfish/Seafood* **Y/N**

Please list any surgeries you have had, with dates: 1._____ 2._____
3._____ 4._____ 5._____

Social History: Do you: Drink Alcohol? **Y/N** How much?_____ Smoke? **Y/N** How much?____ Use Drugs? **Y/N** Type?_____
What is your highest level of education: Grade School High School College/Vocational Graduate
Where do you work?_____ What is your position? _____ Are you **right handed** or **left handed**?
What is your height?_____ Weight?_____
For Women: When was your last menstrual period? _____ Are you post-menopausal? _____

Family History: Please list any health problems in your immediate family: Mother:_____
Father:_____ Other:_____ Do you have children? **Y/N** How many?_____

In the past few weeks have you had any of the following: (*Circle Y or N for all and explain each Y below*)

Fevers, Chills, Weight Loss	**Y/N**	Chest Pain	**Y/N**	Difficulty Breathing	**Y/N**	Seizures	**Y/N**
Bowel/Bladder changes	**Y/N**	Skin Sores	**Y/N**	Bruising/Bleeding	**Y/N**	Vision Changes	**Y/N**
Urinary Infection	**Y/N**	Joint Pain	**Y/N**	Nausea, Vomiting	**Y/N**	Hearing loss	**Y/N**

Other problems:_____
Please explain:_____

Your Signature:_____ Date:_____ Provider's Signature:_____ Date:_____

The above is true and correct to the best of my belief.

Maryland Spine and Brain Specialists, LLC

3407 Wilkens Avenue, Ste 250
Baltimore, MD 21229

Raymond I. Haroun, M.D.
Diplomate
American Board of Neurological Surgery

Phone 410-646-4800
Fax 410-646-9700

Authorization for Release of Medical Records

I, _____, hereby authorize you to release to Dr. Raymond Haroun, and/or Maryland Spine and Brain Specialists, LLC., a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

_____ _____
(Signature) (Date)

****This authorization will expire exactly one year from the date which it was signed****

Welcome to our office:

Following is a list of our updated office policies and procedures.

- Office hours are Monday thru Friday 8:30am-4pm. The office is closed from 12:00pm to 1:00pm for lunch. For routine matters such as prescription refills and appointments please call during regular business hours. Pager numbers are for emergencies only.
- Office visits are by appointment only. Additionally, if you arrive without the necessary paperwork and/or are more than 15 minutes late for a scheduled appointment, your appointment may need to be rescheduled.
- In order for you to receive the best possible care, it is essential that you follow the physician's treatment plan. If the doctor sends you for any studies, testing, or consultations with other physicians, please have these completed before your next appointment or it may need to be rescheduled. ***It is essential for you to call to schedule an appointment for these results.***
- Referrals, copays, deductibles, and coinsurance are **required** at the time of your appointment. If your medical insurance requires you to have a referral to see a specialist, it will need to be presented BEFORE you see the doctor. If your primary doctor is faxing a referral, we recommend that you contact our office prior to arriving for your scheduled appointment to make sure we have received the referral. We will not call your primary doctor for a referral at the time of your visit. If you arrive without copay, deductible, coinsurance and/or referral your appointment may need to be rescheduled.
- For copayments we accept cash and/or credit cards except American Express.
- For payments on a previous balance or for surgeries we accept cash, personal check (72 hours in advance) and/or credit cards except American Express. Our fee for cancelled or returned checks is $25.
- All forms such as disability paperwork and attorney requests will be handled within 10-14 business days from the date in which they are received. We will automatically generate a generic disability form free of charge. If your insurance company requires that its own form be filled out, there is a $25 fee associated with this. This fee is payable in advance, before the forms are completed by our office.
- It is essential that we are made aware of any changes in address, phone number, insurance, etc. Without advising us of insurance changes, you may be responsible for bills sent to an insurance carrier with whom you are no longer covered.
- In order for our office to review and process prescriptions, requests for medication must be made at least five (5) business days in advance. Please note that we generally cannot fulfill same day prescription requests.
- We can generally prescribe pain medications within your three month post operative period. If you still require routine pain medication after that time, you may need a referral to a pain management specialist. Referrals will be handled on an individual basis.
- If, during a period of 12 months, you miss more than three scheduled appointments, you will be discharged from our practice.
- Any imaging studies left in our office for more than 30 days will become the property of our office and are subject to immediate destruction. Please note that all films will be destroyed in compliance with HIPPA regulations.

I understand that my signature below certifies that I have read, understand, agree to and have received a copy of, the above policies and procedures.

_____ _____

Signature Date