Portland NEUROSURGERY
JEFFREY P. JOHNSON, M.D., FACS
Physician & Surgeon

CARMEL D. WIMBER, PA-C

Providence St. Vincent Medical Center
9155 SW Barnes Road, Suite 836
Portland, Oregon 97225

Phone: (503) 291-1960 | Fax: (503) 297-9195
TIN 93-0768280
www.portlandneurosurgery.com

Welcome to our Clinic! Our goal is to provide you with the highest quality medical care available. Please **bring the completed enclosed paperwork** along with your **insurance card and legal picture ID** to your appointment. To protect your identity we will be taking a photo copy of your ID for your chart. **Also, remember to bring any imaging or medical reports regarding your condition, as we will be unable to see you without them**. Parking is available in the 9l·ăű Parking Garage. **Please allow 10-15 minutes for parking.**

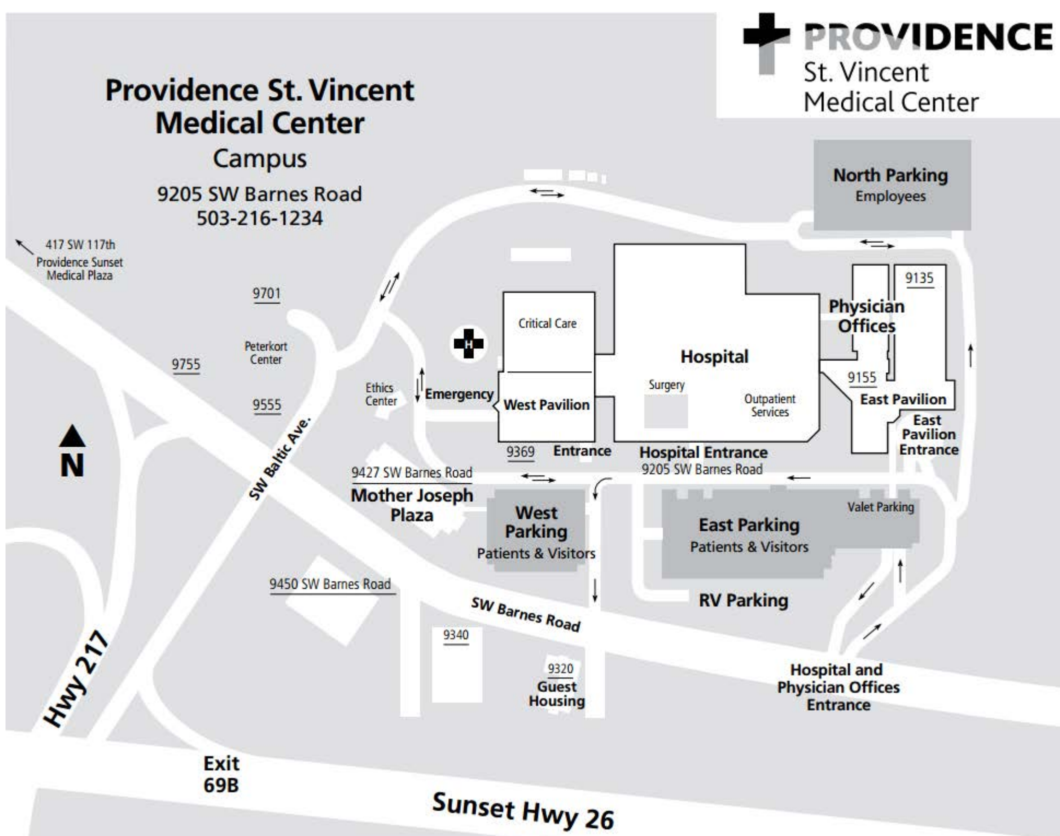
You are responsible for securing referrals from your Primary Care Physician if required by your insurance. If a referral is required and not in place at the time of your appointment it will be necessary to reschedule.

How to find usƔ We are ƚŷűKŜ 9l·ăű tl·ǿƚƚƨŷ aŜŘƚÕl·ſ tKèăƚÕƚl·ŷ hŦŦƚÕŜ .ďƶſŘƚŷƎ ǿKƚÕK ƚă l·Řǝl·ÕŜŷű űƻ St. Vincent Hospitalؙ ¢he hospital is located near the interchange of highway 217 and (US 26).

From PortlandƔ Sunset Highway (US 26) west to Barnes Rd exit, turn right and follow signs to St. Vincent Hospital
From WestƔ Sunset Highway (US 26) east to Barnes Rd exit, turn right under Sunset Highway to the north, then follow signs to St. Vincent Hospital
From SouthƔ Hǿy 217 north to Barnes Rd. then right and follow signs to St. Vincent Hospital

We look forward to seeing you.

OFFICE HOURS
Mon-Fri 8:30- 5:00
We are closed from 12-1


PROVIDENCE
St. Vincent
Medical Center
Providence St. Vincent
Medical Center
Campus
9205 SW Barnes Road
503-216-1234
417 SW 117th
Providence Sunset
Medical Plaza
North Parking
Employees
9701
Peterkort
Center
9755
9555
Ethics
Center
Emergency
Critical Care
West Pavilion
Hospital
Surgery
Outpatient
Services
Physician
Offices
9135
9155
East Pavilion
East
Pavilion
Entrance
9369
Entrance
Hospital Entrance
9205 SW Barnes Road
SW Baltic Ave.
9427 SW Barnes Road
Mother Joseph
Plaza
West
Parking
Patients & Visitors
East Parking
Patients & Visitors
Valet Parking
RV Parking
N
9450 SW Barnes Road
SW Barnes Road
9340
9320
Guest
Housing
Hospital and
Physician Offices
Entrance
Hwy 217
Exit
69B
Sunset Hwy 26

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PATIENT INFORMATION

Name_____ Date of Birth _____Age_____ Sex M◯ F◯

Address _____City/State/Zip_____

Home Phone_____ Cell Phone _____Work Phone_____

E-Mail Address_____Message Phone_____

Employer_____Phone_____

Spouse/Partner/Guardian _____Phone_____Employer_____

Emergency Contact_____Phone_____Relationship_____

Primary Care Physician_____Phone_____

Referring Physician_____Phone_____

Responsible Party_____Relationship_____

INSURANCE AND PAYMENT INFORMATION

PRIMARY INSURANCE

Carrier_____Phone_____

Subscriber_____Date of Birth_____

Relationship_____ Employer_____

ID#_____ Group#_____

SECONDARY INSURANCE

Carrier_____Phone_____

Subscriber_____ Date of Birth_____

Relationship_____ Employer_____

ID#_____ Group#_____

WORKER'S COMP AND MOTOR VEHICLE CASES Date of Incident_____

Insurance Company Name_____ Case #_____

Adjuster Name_____Phone Number_____

Attorney Name_____Phone Number_____

- We are required to ask these questions to help track and prevent disparities in healthcare

Race ◯American Indian or Alaska Native ◯Native Hawaiian or Pacific Islander ◯Asian ◯White ◯Black or African American ◯Other ◯Decline

Ethnicity ◯Hispanic or Latino ◯Not Hispanic or Latino ◯Decline Preferred Language _____

AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand and voluntarily consent to and authorize the following:

Guarantee of Payment I authorize Portland Neurosurgery to release to my insurance company any information concerning my medical care in order to process my claim. I also assign medical payments from my insurance company to Portland Neurosurgery, I understand that I am personally responsible for all charges from Portland Neurosurgery whether paid for or not and guarantee payment of the bill.

Release of Medical Records I authorize Portland Neurosurgery to use and disclose verbally, electronically and/or in writing health information about me for purposes of treatment to ensure continuity of care and payment of charges. I understand that I have the right to ask that some or all of my health information not be used or disclosed.

Receipt of Privacy Practices By signing this form I acknowledge that a copy of the Notice of Privacy Practices which describes how Portland Neurosurgery will handle health information about me is available upon request.

Signature_____Date_____

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Medical History Form

Name _____ **Date of Birth**_____

Primary Care Provider _____ **Today's date** _____

Do you have any of the following medical conditions (Check all that apply)?

☐ High blood pressure	☐ Stroke	☐ Emphysema
☐ Diabetes	☐ Asthma	☐ Heart disease
☐ Cancer	☐ High cholesterol	

Other (please list)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Surgery (please list type and year)

_____ _____ _____
_____ _____ _____

Other Hospitalizations (reason and year)

_____ _____ _____
_____ _____ _____

	Yes	No
Do you have a history of Sleep Apnea?	☐	☐
If yes, do you use a CPAP machine?	☐	☐
Have you ever had a surgical wound infection?	☐	☐
Have you ever been diagnosed with MRSA?	☐	☐

Are you currently working? ☐ Yes ☐ No

If yes, what is your occupation? _____

Are you ☐ retired ☐ disabled?

Are you ☐ Married/Partnered ☐ Single ☐ Divorced ☐ Widowed?

Do you currently use tobacco? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No

Please Complete Both Sides!

Have any family members had any of the following?

	relationship
☐ Heart disease	_____
☐ Diabetes	_____
☐ Stroke	_____
☐ Cancer	_____
☐ Anesthetic complications	_____

Systems Review (Please check all that apply)

Constitutional

☐ Weight loss
☐ Night sweats
☐ Fatigue or lethargy
☐ Change in sleep patterns
☐ Loss of appetite
☐ Fevers
☐ Itching or rash
☐ Unexplained falls

Eyes

☐ Change in vision
☐ Eye pain
☐ Double vision
☐ Blind spots

Ears, nose, mouth, and throat

☐ Runny nose
☐ Nosebleeds
☐ Sinus pain
☐ Ringing in the ears
☐ Toothache
☐ Sore throat
☐ Painful swallowing

Cardiovascular

☐ Chest pain
☐ Exercise intolerance
☐ Swelling in legs or feet
☐ Palpitations
☐ Loss of consciousness

Respiratory

☐ Cough
☐ Shortness of breath
☐ Coughing up blood
☐ Sputum

Gastrointestinal

☐ Abdominal Pain
☐ Indigestion
☐ Nausea or vomiting
☐ Diarrhea or constipation
☐ Vomiting blood
☐ Blood in stools

Genitourinary

☐ Loss of bladder control
☐ Blood in urine
☐ Painful urination
☐ Excessive menstrual bleeding

Musculoskeletal

☐ Joint pain
☐ Joint swelling
☐ Decreased range of motion

Skin/breast

☐ Rash
☐ Itching
☐ Wounds
☐ Eczema
☐ Breast pain or discharge

Neurological

☐ Seizures
☐ Headaches
☐ Poor balance
☐ Speech problems
☐ Tremor

Psychiatric

☐ Depression
☐ Anxiety
☐ Difficulty concentrating
☐ Mood swings

Endocrine

☐ Thyroid dysfunction
☐ Excessive thirst or urination
☐ Change in menstrual periods

Hematologic

☐ Anemia
☐ Bruising
☐ Excessive bleeding after surgery or dental work
☐ History of blood transfusion
☐ Family history of hemophilia or other bleeding problems

Allergic/Immunologic

☐ Allergic reaction to medication
☐ Food or environmental allergies

Please Complete Both Sides!

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Medication List

Name _____ **Date of Birth**_____

Primary Care Provider _____ **Today's date** _____

Medication	Dose	Frequency

Medication Allergies/Sensitivities

Medication	Reaction