

**STEPHEN R. NEECE, MD, PA**

4401 Coit Rd. Suite 403, Frisco, TX 75035

Ph: 972-334-0300 / Fax: 214-872-3496

**REGISTRATION FORM**

(Please Print)

| Today's Date:  |                                  |   |                      | PCP:  |   |  |   |
|--|----------------------------------|---|----------------------|---|---|--|---|
| PATIENT INFORMATION  |                                  |   |                      |   |   |  |   |
| Patient's last name:   |                                  | First:                                      | Middle:              | <input type="checkbox"/> Mr.<br><input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss<br><input type="checkbox"/> Ms. | Marital status:<br>Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/> |   |
| Is this your legal name?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | (Former name):                              |                      |   | Birth date:   | Age:   | Sex:<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Street address:  |                                  |   | Social Security no.: |   | Home phone no.:<br>( )  |  |   |
| P.O. box:  |                                  | City:                                       |                      | State:  |   | ZIP Code:  |   |
| Occupation:  |                                  | Employer:                                   |                      |   | Employer phone no.:<br>( )                                    |  |   |
| Chose clinic because/referred to clinic by (Please check one box):                   |                                  |   |                      | <input type="checkbox"/> Dr.                                  |   | <input type="checkbox"/> Insurance plan  | <input type="checkbox"/> Hospital                             |
| <input type="checkbox"/> Family  | <input type="checkbox"/> Friend  | <input type="checkbox"/> Close to home/work |                      | <input type="checkbox"/> Yellow Pages                         |   | <input type="checkbox"/> Other   |   |
| Other family members seen here:  |                                  |   |                      |   |   |  |   |

| INSURANCE INFORMATION  |           |                               |                                 |                                |                                |                            |  |
|--|-----------|-------------------------------|---------------------------------|--------------------------------|--------------------------------|----------------------------|--|
| (Please give your insurance card to the receptionist.)   |           |                               |                                 |                                |                                |                            |  |
| Person responsible for bill:   |           | Birth date:                   | Address (if different):         |                                |                                | Home phone no.:<br>( )     |  |
| Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No        |           |                               |                                 |                                |                                |                            |  |
| Occupation:  | Employer: | Employer address:             |                                 |                                |                                | Employer phone no.:<br>( ) |  |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |           |                               |                                 |                                |                                |                            |  |
| Please indicate primary insurance  |           |                               |                                 |                                |                                |                            |  |
| <input type="checkbox"/> Other   |           |                               |                                 |                                |                                |                            |  |
| Subscriber's name:   |           | Subscriber's S.S. no.:        | Birth date:                     | Group no.:                     | Policy no.:                    | Co-payment:<br>\$          |  |
| Patient's relationship to subscriber:  |           | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other |                            |  |
| Name of secondary insurance (if applicable):   |           | Subscriber's name:            |                                 | Group no.:                     | Policy no.:                    |                            |  |
| Patient's relationship to subscriber:  |           | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other |                            |  |

| IN CASE OF EMERGENCY   |  |                          |                        |
|--|--|--------------------------|------------------------|
| Name of local friend or relative (not living at same address):   |  | Relationship to patient: | Home phone no.:<br>( ) |
|  |  |                          | Work phone no.:<br>( ) |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Stephen R. Neece, MD, PA or insurance company to release any information required to process my claims. |  |                          |                        |
| _____<br><i>Patient/Guardian signature</i>   |  | _____<br><i>Date</i>     |                        |

**STEPHEN R. NEECE, M.D., F.A.C.S.**

**PERSONAL INFORMATION:**

**DATE:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**Right Handed**   **Left Handed**   **Referred by:** \_\_\_\_\_

**CURRENT MEDICAL HISTORY:**

**In your own words, please describe your current complaints and why you are seeing the doctor today** \_\_\_\_\_  
\_\_\_\_\_

---

**PAST MEDICAL HISTORY:**

**Please check if you have ever had any of the following illnesses or medical problems:**

- |                                  |                               |
|----------------------------------|-------------------------------|
| Seizures (Type _____)            | Cancer (Type: _____)          |
| Migraine Headaches               | Hay Fever                     |
| Tension Headaches                | Asthma                        |
| Head Injury                      | Emphysema                     |
| Neck Injury                      | Tuberculosis                  |
| Back Injury                      | Chronic Cough/Pneumonia       |
| Nervous Breakdown/Panic Attacks  | Stomach Ulcer/Reflux          |
| High Blood Pressure/Heart Attach | Hepatitis (A____B____C____)   |
| High Cholesterol/Triglycerides   | Colon Problems/Ulcers/Chron's |
| Measles/Mumps/Chicken Pox        | Diabetes                      |
| Anemia/Bleeding Problems         | Rheumatic Fever/Scarlet Fever |
| Thyroid Disease                  | Kidney Disease                |
| Glaucoma                         | Arthritis/Rheumatism          |
| Fibromyalgia                     | Gout                          |
|                                  | Lyme Disease                  |

**LIST ANY SURGERIES/HOSPITALIZATIONS:**

**DATE:**

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**CURRENT MEDICATIONS:** \_\_\_\_\_  
\_\_\_\_\_

**MEDICATION ALLERGIES:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**STEPHEN R. NEECE, MD, FACS**

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**PERSONAL HISTORY:**

Place of Birth (city and state): \_\_\_\_\_

Current residence (city): \_\_\_\_\_ How long: \_\_\_\_\_

Education: Highest level achieved: \_\_\_\_\_ High school grad? \_\_\_\_\_

College grad? \_\_\_\_\_ Post graduate training? \_\_\_\_\_

Occupation: \_\_\_\_\_ How long? \_\_\_\_\_

Legal problems now or in the past? \_\_\_\_\_

Product \_\_\_\_\_ Personal Injury \_\_\_\_\_ Comp \_\_\_\_\_ Disability rating? \_\_\_\_\_

Military service: \_\_\_\_\_ Branch: \_\_\_\_\_ Years: \_\_\_\_\_ Type of discharge \_\_\_\_\_

Do you smoke: \_\_\_\_\_ amt./frequency: \_\_\_\_\_ use alcohol: \_\_\_\_\_ amt./frequency: \_\_\_\_\_

**Family History:**

**IF LIVING**

**IF**

**DECEASED**

|            | AGE | HEALTH | AGE AT DEATH | CAUSE |
|------------|-----|--------|--------------|-------|
| SPOUSE     |     |        |              |       |
| FATHER     |     |        |              |       |
| MOTHER     |     |        |              |       |
| BROTHER(S) |     |        |              |       |
|            |     |        |              |       |
| SISTER(S)  |     |        |              |       |
|            |     |        |              |       |
| CHILDREN   |     |        |              |       |
|            |     |        |              |       |

Are there any hereditary diseases in your family? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please specify: \_\_\_\_\_

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

STEPHEN R. NEECE, MD, FACS

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**REVIEW OF SYMPTOMS/CONDITIONS:** Check if you experience any of the following:

**GENERAL:**

\_\_\_\_\_ Tired all the time                      \_\_\_\_\_ Weight loss                      \_\_\_\_\_ Weight gain

**SKIN:**

\_\_\_\_\_ Rash                                      \_\_\_\_\_ Itching                                      \_\_\_\_\_ Psoriasis  
\_\_\_\_\_ Poor healing                              \_\_\_\_\_ Wounds/Sores                              \_\_\_\_\_ Skin cancer

**EYES:**

\_\_\_\_\_ Lost of vision in one eye                      \_\_\_\_\_ Blurry vision                                      \_\_\_\_\_ Halo around lights  
\_\_\_\_\_ Eye pain                                      \_\_\_\_\_ Double vision                                      \_\_\_\_\_ Poor night vision  
\_\_\_\_\_ Glaucoma                                      \_\_\_\_\_ Cataracts

**EARS/NOSE/THROAT:**

\_\_\_\_\_ Hearing loss                                      \_\_\_\_\_ Ringing in ears                                      \_\_\_\_\_ Earache/discharge  
\_\_\_\_\_ Nasal stuffiness                                      \_\_\_\_\_ Nosebleeds                                      \_\_\_\_\_ Trouble swallowing  
\_\_\_\_\_ Lump in your throat                                      \_\_\_\_\_ Hoarseness                                      \_\_\_\_\_ Sore mouth  
\_\_\_\_\_ Sore tongue

**RESPIRATORY:**

\_\_\_\_\_ Constant cough                                      \_\_\_\_\_ Wheezing                                      \_\_\_\_\_ Coughing blood  
\_\_\_\_\_ Shortness of breath                                      \_\_\_\_\_ Emphysema                                      \_\_\_\_\_ Asthma

**CARDIOVASCULAR:**

\_\_\_\_\_ Irregular heartbeat                                      \_\_\_\_\_ Chest pain                                      \_\_\_\_\_ Swelling in your feet  
\_\_\_\_\_ Heart murmur                                      \_\_\_\_\_ Enlarged heart                                      \_\_\_\_\_ Valve problem

**GASTROINTESTINAL:**

\_\_\_\_\_ Change in eating habits                                      \_\_\_\_\_ Constipation                                      \_\_\_\_\_ Diarrhea  
\_\_\_\_\_ Irritable bowel                                      \_\_\_\_\_ Vomiting blood                                      \_\_\_\_\_ Blood in stool  
\_\_\_\_\_ Loss of bowel control

**GENITOURINARY:**

\_\_\_\_\_ Loss of bladder control                                      \_\_\_\_\_ Blood in urine                                      \_\_\_\_\_ Frequent infection  
\_\_\_\_\_ Pain when urinating                                      \_\_\_\_\_ Prostate problem                                      \_\_\_\_\_ Trouble passing water  
\_\_\_\_\_ Leaky bladder

**MUSCULOSKELETAL:**

\_\_\_\_\_ Joint pain or stiffness                                      \_\_\_\_\_ Knee pain                                      \_\_\_\_\_ Hip pain  
\_\_\_\_\_ Back pain                                      \_\_\_\_\_ Neck pain                                      \_\_\_\_\_ Wrist pain  
\_\_\_\_\_ Pain in legs at night                                      \_\_\_\_\_ Morning stiffness                                      \_\_\_\_\_ Muscle soreness  
\_\_\_\_\_ Jaw pain

**DO YOU:**

\_\_\_\_\_ Have trouble sleeping                                      \_\_\_\_\_ Sleep too much                                      \_\_\_\_\_ Snore  
\_\_\_\_\_ Stop breathing at night                                      \_\_\_\_\_ Sleep walk                                      \_\_\_\_\_ Have nightmares  
\_\_\_\_\_ Fall asleep at work                                      \_\_\_\_\_ Fall asleep in car                                      \_\_\_\_\_ Have memory lapses

**DO YOU:**

\_\_\_\_\_ Feel nervous                                      \_\_\_\_\_ Feel depressed                                      \_\_\_\_\_ Cry for no reason  
\_\_\_\_\_ Want to commit suicide                                      \_\_\_\_\_ Hear voices or see objects or people not there  
\_\_\_\_\_ Have the feeling that someone is trying to harm you  
\_\_\_\_\_ Have any psychiatric hospitalization

**STEPHEN R. NEECE, MD, FACS**  
**PAIN ASSESSMENT FORM**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

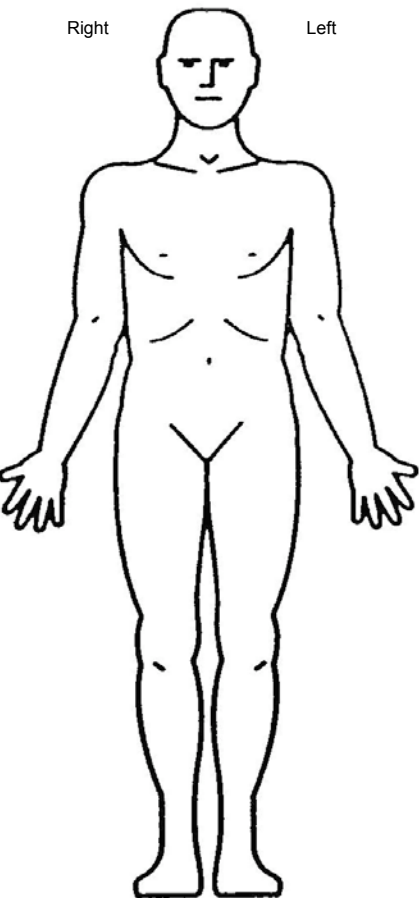
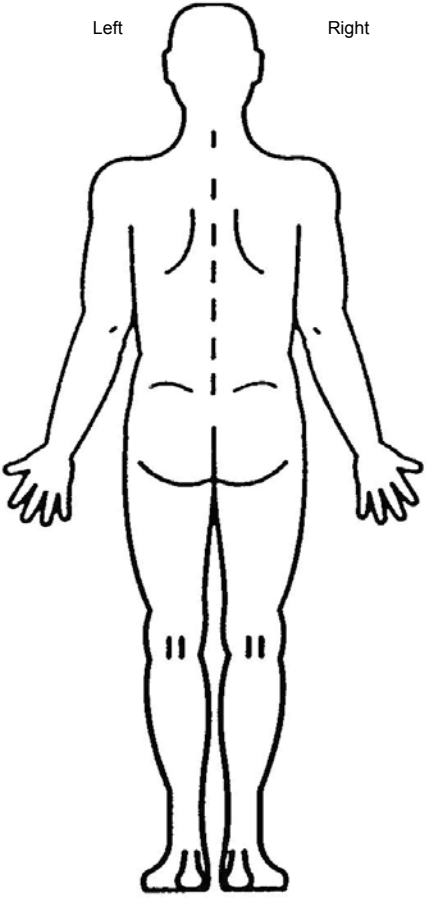
Date: \_\_\_\_\_ Time: \_\_\_\_\_

On the diagrams below, mark the areas on your body where you feel the sensations described below using the appropriate symbol. Mark the areas of radiation, including all affected areas.

|                       |                         |                                   |                        |                         |
|-----------------------|-------------------------|-----------------------------------|------------------------|-------------------------|
| <u>ACHING</u><br>++++ | <u>NUMBNESS</u><br>==== | <u>PINS &amp; NEEDLES</u><br>0000 | <u>BURNING</u><br>XXXX | <u>STABBING</u><br>//// |
|-----------------------|-------------------------|-----------------------------------|------------------------|-------------------------|

|       |  |      |
|-------|--|------|
| Right |  | Left |
|-------|--|------|

**Pain Intensity Scale**

Circle the area on the scale below that best describes how you rate the intensity of the pain that you are experiencing:

"0" being no pain and "10" being worst possible pain.

|         |   |   |   |          |   |   |   |   |       |
|---------|---|---|---|----------|---|---|---|---|-------|
| 1       | 2 | 3 | 4 | 5        | 6 | 7 | 8 | 9 | 10    |
| No Pain |   |   |   | Moderate |   |   |   |   | Worst |
|         |   |   |   |          |   |   |   |   |       |

**STEPHEN R. NEECE, MD, PA**  
**PF-1000**

**Notice of Privacy Practices**  
**Uses and disclosures**

**THIS NOTICE  
DESCRIBES HOW  
MEDICAL INFORMATION  
ABOUT YOU MAY BE  
USED AND DISCLOSED  
AND HOW YOU CAN GET  
ACCESS TO THIS  
INFORMATION.**

**PLEASE REVIEW IT  
CAREFULLY.**

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

**Additional Uses of Information**

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail and/or the US mail.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

## **Stephen R. Neece, MD, PA-Notice of Privacy Practices-Page 2**

### **Individual Rights**

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

### **Practice Duties**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

### **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### **Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address shown below. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

### **Contact Person**

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer  
Stephen R. Neece, MD, PA  
4401 Coit Rd., Suite 403  
Frisco, TX 75035  
972-334-0300

### **Effective Date**

This Notice is effective on or after October 5, 2007.

**Stephen R. Neece, MD, PA**  
**PF-2000**

**Acknowledgement of Receipt of Notice of Privacy Practices**

Our practice reserves the right to modify the privacy practices outlined in the notice.

**Signature**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

\_\_\_\_\_  
Name of Patient (Please Print)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative (Required if the Patient is a minor or an adult who is unable to sign the form)

\_\_\_\_\_  
Relationship of Patient Representative to Patient