Dear: __________________________,

You are scheduled for an appointment with:

☐ Fredrick Junn, MD
☐ Tejpal Pannu, MD

Your appointment is scheduled for:

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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_______________________________ at ______________ am / pm.

In order to provide you with the best care possible, please fill out the enclosed packet and bring it with you on your appointment day. Please note: All missed appointments may result in a $25 fee. If you must cancel an appointment, please allow our office a 24 hour notice.

If you have recently had an MRI, CT Scan, or X-Ray of the brain, neck, chest, or spine, it is sometimes helpful to bring if it is readily available. Also, please bring a list of current medications that you are taking so the doctor may better evaluate you.

You are responsible for bringing any referrals that are required by your particular insurance carrier.

We look forward to seeing you and assisting you with your health care needs.
**OAKWOOD BRAIN & SPINE CENTER**

*Dr. Fredrick Junn*  
*Dr. Tejpal Pannu*

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<tr>
<th>Name: _______________________________</th>
<th>Home Phone: _______________________________</th>
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| Address: ______________________________ | Cell Phone: _______________________________
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<tr>
<td>_______________________________</td>
<td>Birthdate: _______________________________</td>
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<td>Email: _______________________________</td>
<td>SS#: _______________________________</td>
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<tr>
<td>Emergency Contact: _______________________________</td>
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</tr>
<tr>
<td>Phone: _______________________________</td>
<td>Relationship: _______________________________</td>
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</tbody>
</table>

**Race:**  
- ☐ Caucasian  
- ☐ African American  
- ☐ Asian  
- ☐ Hispanic  
- ☐ Other

**Ethnicity:**  
- ☐ Hispanic  
- ☐ Not Hispanic

**Language:**  
- ☐ English  
- ☐ Spanish  
- ☐ Arabic

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**Primary Insurance:**  

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<tr>
<th>Subscriber/ID#: _______________________________</th>
<th>Group #: _______________________________</th>
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<tbody>
<tr>
<td>Subscribers Name: _______________________________</td>
<td>Subscribers SS#: _______________________________</td>
</tr>
<tr>
<td>Relationship to Patient: _______________________________</td>
<td>Subscribers Birthdate: _______________________________</td>
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<tr>
<td>Subscribers Employer: _______________________________</td>
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*NOTE: If you are not the subscriber, then you MUST fill out subscribers name, SS#, birthdate and employer.*

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**Secondary Insurance:**  

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<th>Subscriber/ID#: _______________________________</th>
<th>Group #: _______________________________</th>
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<tbody>
<tr>
<td>Subscribers Name: _______________________________</td>
<td>Subscribers SS#: _______________________________</td>
</tr>
<tr>
<td>Relationship to Patient: _______________________________</td>
<td>Subscribers Birthdate: _______________________________</td>
</tr>
<tr>
<td>Subscribers Employer: _______________________________</td>
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</table>

*NOTE: If you are not the subscriber, then you MUST fill out subscribers name, SS#, birthdate and employer.*

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**Family Physician**

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<tr>
<th>Name: _______________________________</th>
<th>Address: _______________________________</th>
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<tr>
<td>Phone: _______________________________</td>
<td>Fax: _______________________________</td>
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**Referring Physician**

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<th>Name: _______________________________</th>
<th>Address: _______________________________</th>
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<tr>
<td>Phone: _______________________________</td>
<td>Fax: _______________________________</td>
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</table>
**MEDICAL HISTORY**

Pharmacy Name: ________________________________ Phone: __________________________

Address: ________________________________ Fax: __________________________

Medication List:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage (MG)</th>
<th>Frequency</th>
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Have you ever been diagnosed with the following?

- Diabetes
- Hypertension
- High Cholesterol
- Cancer
- Heart Trouble
- Arthritis
- Parkinson’s disease
- Essential Tremor
- Dystonia
- Seizures/Epilepsy
- Thyroid Disorder

Allergies and Sensitivities:

<table>
<thead>
<tr>
<th>Name</th>
<th>Reaction</th>
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</table>
Past Surgical Procedures:

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
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Have you ever been hospitalized?
- Yes  Please explain: ____________________________________________
- No

Family History:

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>F</th>
<th>S/B</th>
<th>GP</th>
<th>A/U</th>
<th></th>
<th>M</th>
<th>F</th>
<th>S/B</th>
<th>GP</th>
<th>A/U</th>
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<tbody>
<tr>
<td>High Blood Pressure</td>
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<td></td>
<td>Stroke</td>
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<tr>
<td>Allergies/Asthma</td>
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<td>Obesity</td>
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<tr>
<td>Heart Attack</td>
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<td></td>
<td>Alcoholism</td>
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<tr>
<td>Diabetes</td>
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<td>HIV or AIDS</td>
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<tr>
<td>High Cholesterol</td>
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<td>Glaucoma</td>
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<td>Cancer</td>
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<td>Seizures</td>
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<tr>
<td>Arthritis</td>
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<td></td>
<td>Thyroid Disorder</td>
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<tr>
<td>Kidney Stones</td>
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<td>Reaction to Anesthetics</td>
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<td>Bleeding Disorder</td>
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Siblings: # of Brothers: ___________  # of Sisters: ___________

Children: # of Sons: _____________  # of Daughters: ________
## Social History:

**Marital Status:**
- Single
- Married
- Divorced
- Widowed

**Education:**
- Elementary School
- High School
- Some College
- College Degree
- Advanced Degree

**Dominant Hand:**
- Right
- Left

**Occupation:**
- Employed
- Retired
- Unemployed
- Student
- Disabled

**Occupational Exposure:**
- Yes
- No

**Alcohol:**
- Yes
- No

**Smoking:**
- Current Smoker
  - P.P.D. ______
  - #Years______
- Former Smoker
  - PPD ______
  - Years______
- Never Smoked

**Drugs:**
- Yes
- No

**Are you Claustrophobic?**
- Yes
- No

**Do you use an Intrauterine Device (IUD)?**
- Yes
- No

**Do you have any cerebral aneurysm clips, stents, or skin patches?**
- Yes
- No

**Do you have a Pacemaker?**
- Yes
- No

**Have you had a heart valve replacement?**
- Yes
- No

**Do you have any metallic implants in your body?**
- Yes, where:
  - ______________________
- No

**Are you Diabetic?**
- Yes
  - And I take Glucophage
  - And I take Glucovance
  - And I take Avandamet
- No

**Do you have any allergies to Iodine Contrast?**
- Yes
- No

**Do you have renal disease?**
- Yes
- No

**Do you have children living at home?**
- Yes
- No

**Do you live in a nursing home?**
- Yes
- No
Review of Systems

General:
- Weakness
- Chills
- Change in weight, appetite, or sleeping
- Fatigue
- Night sweats

Eyes:
- Glasses or contacts
- Excessive tearing or discharge
- Blank spots in your vision
- Eye pain
- Double vision
- Last eye exam: ____________

Ears, Nose, Throat:
- Loss/trouble hearing
- Ringing in ears
- Frequent earaches
- Post nasal drip
- Sinus pain
- Hoarseness
- Bleeding gums
- Drainage
- Nosebleeds
- Blockage of nose
- Sore throat
- Dentures
- Toothaches
- Last dental exam: ____________

Lungs:
- Cough
- Shortness of breath
- Positive TB test
- Last chest x-ray: ____________
- Wheezing
- Spitting up blood

Heart:
- Chest pain
- Palpitations (heart pounding)
- Trouble breathing at night
- Fatigue easily with exercise
- Ankle swelling

Skin:
- Itching
- Rash
- Change in color
- Change in warts, moles, or birthmarks

Breasts:
- Lumps in breasts
- Discharge from nipple
- Last mammogram: ____________

Gastrointestinal:
- Vomiting
- Difficulty swallowing
- Stomach or abdominal pain
- Indigestion or heartburn
- Ulcers
- Changes in bowel habits
- Blood in stools (black stools)
- Hemorrhoids
- Last colonoscopy: ____________

Musculoskeletal:
- Pain
- Weakness
- Deformity
- Joint swelling
- stiffness
- Twitching
- Chronic back pain

Vaginal & Urinary (Female):
- Vaginal itching or burning
- Vaginal discharge
- STD: ________________________
- Sexual difficulties
- Last menstrual period: ____________
- Last pap smear: ________________
- Method of contraception: ____________
- Pregnancy number: _______
- Problems during pregnancy
- Miscarriages or abortions number: _______
- Blood in urine
- Kidney stones
- Trouble starting stream
- Incontinence (leaking)

Genitals & Urinary (Male):
- Hernia
- Discharge from penis
- Pain or lump in testicles
- Method of contraception: ____________
- STD: ________________________
- Sexual difficulties
- Pain or frequent urination
- Previous urinary infection
- Blood in urine
- Kidney stones
- Trouble starting stream
- Incontinence (leaking)

Hematologic & Lymphatic:
- Easy bruising or bleeding problems
- Swollen lymph nodes

Endocrine:
- Excessive Hot
- Excessive Cold
- Always Thirsty
- Always Hungry

Nervous System:
- Headaches
- Head injury
- Dizziness or passing out
- Loss of coordination or balance
- Numbness
- Seizures

Psychological:
- Nervousness or anxiety
- Depression
- Nightmares
- Unable to sleep
- Memory loss
WAIVER OF LIABILITY

CONSENT: I request and authorize health care as my physician and his/her designees may deem advisable. This may include routine diagnostic, radiology, and laboratory procedures and medication administration.

RELEASE: I authorize the release of medical and other information to my insurance company for review of my coverage and/or for the processing of claims for services rendered to me or my child. I permit a copy of this authorization to be used in place of the original.

PAYMENT: I assign and authorize payment for any and all services rendered to:

Oakwood Group IX-Oakwood Neuroscience Center

From my insurance company or third party payor including, but not limited to, Medicare, Medicaid, commercial health insurance, automobile and no fault insurances and workers disability compensation insurance. I understand that I am responsible for any charges incurred that are not covered by my insurance company. I understand that I am responsible for my insurance co-pay at the time of my visit.

I have read and understand this information.

__________________________________________________________
(Responsible Party Signature)                                         (Date Signed)

UNDERSTANDING OF CANCELLATION POLICY

By signing this document, I verify that I acknowledge and understand the appointment cancellation policy of the Oakwood Brain & Spine Center. I am aware and understand that if I fail to show for a scheduled appointment without prior notice, I may be charged a $25.00 fee.

Patient Signature: ___________________________________________  Date: _________________
NOTICE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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.

We are committed to protecting the privacy of our patients’ personal and health information. All of our employees are required to sign confidentiality agreements and are required to comply with our confidentiality policies.

We may use or disclose your protected health information for purposes of treatment, payment, or practice operations only with your written consent. For example, we may contact another physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. We must obtain your written authorization for any other use or disclosure. You may revoke your consent at any time in writing only. This will not apply to information used or disclosed while the consent was in effect.

We will provide access to your information, without your consent, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefits programs, employers (in cases of work-related illness or injury), courts and administrative tribunals.

You have the right to access and amend your information, request an accounting of any disclosures, request restrictions on use and disclosure of your information, request a copy of this notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this notice.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the most current notice in effect. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a revised notice by mail.

I give permission for the Oakwood Brain & Spine Center to access my pharmacy benefits data electronically through RxHub. This consent will enable them to determine the pharmacy benefits and drug co-pays for my health plan, check whether a prescribed medication is covered under my plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if my health plan allows electronic prescribing to mail order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by any provider.

If you believe that your rights have been violated, you may complain to us or the Secretary of the US Department of Health and Human Services. We will not retaliate against you for filing a complaint.

For more information, please contact us at (313) 982-5290. This notice is effective: ______________

Please indicate if there is a friend or family member to whom we are allowed to release medical information to:

Name: ___________________________  Phone: ___________________________

Please indicate if there is a friend or family member to whom we are NOT allowed to release medical information to:

Name: ___________________________  Phone: ___________________________

The undersigned acknowledges that he/she has received a copy of this notice.

________________________________________________________________________

(Patient Signature)  (Date Signed)