

Neurosurgical Specialists of El Paso, PLLC  
Dr. Bratislav Velimirovic  
(915) 633-1916

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ E-mail: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
(FECHA DE HOY) (CORREO ELECTRONICO) (TELEFONO CELULAR)

Patient's Name: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
(NOMBRE DEL PACIENTE) (SEGURO SOCIAL)

Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(DOMICILIO) (TELEFONO DE CASA) (FECHA DE NACIMIENTO)

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Gender:  Female  Male  
(CIUDAD Y ESTADO) (CODIGO)

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Occupation: \_\_\_\_\_  
(EMPLEADOR) (TELEFONO DE EMPLEADOR) (OCUPACION)

Work Address, City, State: \_\_\_\_\_  
(DOMICILIO DE EMPLEADOR, CIUDAD, Y ESTADO)

**WHO REFERRED YOU HERE:**

Brochure/Family/YellowPages/Newspaper/Hospital/Doctor: \_\_\_\_\_

**QUIEN LE REFIRIO AQUI:**

Folleto/Familia/Pagina Amarillas/Periodico/Hospital/Doctor: \_\_\_\_\_

Date of Accident or Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hurt on the Job \_\_\_Yes/Si \_\_\_ No MVA \_\_\_ Yes/Si \_\_\_ No  
(FECHA DE ACCIDENTE) (FUE LASTIMADO EN EL TRABAJO) (ACCIDENTE DE VEHICULO DE MOTOR)

Emergency Contact Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
(EN CASO DE EMERGENCIA A QUIEN NOTIFICAMOS) (TELEFONO DE CASA/CELULAR)

Emergency Contact Relationship to Patient: \_\_\_\_\_  
(RELACION AL PACIENTE)

**PRIMARY INSURANCE INFORMATION**  
(INFORMACION DE ASEGURANZA PRIMARIA)

(provide your insurance card to the front desk at check-in)

Insurance Company: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
(COMPANIA DE ASEGURANZA Y TELEFONO DE ASEGURANZA)

Name of Insured: \_\_\_\_\_ Patient Relationship to Insured: \_\_\_\_\_  
(NOMBRE DE LA PERSONA ASEGURADA) (RELACION AL PACIENTE)

Subscriber ID (Policy #): \_\_\_\_\_ Group ID: \_\_\_\_\_ Social Security: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(IDENTIFICACION DE POLIZA) (NUMERO DE GRUPO) (SEGURO SOCIAL)

Effective Date: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (FECHA DE NACIMIENTO)

**SECONDARY INSURANCE INFORMATION**  
(INFORMACION DE ASEGURANZA SECUNDARIA)

(provide your insurance card to the front desk at check-in)

Insurance Company: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
(COMPANIA DE ASEGURANZA Y TELEFONO DE ASEGURANZA)

Name of Insured: \_\_\_\_\_ Patient Relationship to Insured: \_\_\_\_\_  
(NOMBRE DE LA PERSONA ASEGURADA) (RELACION AL PACIENTE)

Subscriber ID (Policy #): \_\_\_\_\_ Group ID: \_\_\_\_\_ Social Security: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(IDENTIFICACION DE POLIZA) (NUMERO DE GRUPO) (SEGURO SOCIAL)

Effective Date: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (FECHA DE NACIMIENTO)

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

(ESTOY DE ACUERDO EN QUE LA INFORMACION FACILITADO EN ESTE FORMULARIO ES PRECISA Y HASTA LA FECHA A LO MEJOR DE MI CONOCIMIENTO.

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



NEUROSURGICAL  
SPECIALISTS  
OF EL PASO, PLLC

**Bratislav Velimirovic, MD**

**Prescription Order Pick-up.** There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician’s office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

(Patient/Representative Initials) I **wish** to designate the following individual to pick up a prescription order on my behalf:

Name:  Date: \_\_\_\_\_

Name:  Date: \_\_\_\_\_

(Patient/ Representative Initials) I **do not want** to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Parent/Guardian/Patient Representative Name (Printed) \_\_\_\_\_

Patient Name (Printed):  Date of Birth:



Bratislav Velimirovic, MD

**PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS**

1. \_\_\_\_\_(Patient or Guardian Initials)

**Financial Agreement.**

I acknowledge, that as a courtesy, **Neurosurgical Specialists of El Paso, PLLC** may bill my insurance company for services provided to me.

I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.

I understand that there is a fee for returned checks.

2. \_\_\_\_\_(Patient or Guardian Initials)

**Third Party Collection.** I acknowledge that **Neurosurgical Specialists of El Paso, PLLC** may utilize the services of a third party business associate or affiliated entity as an extended business office (“EBO Servicer”) for medical account billing and servicing.

3. \_\_\_\_\_(Patient or Guardian Initials)

**Assignment of Benefits.** I hereby assign to **Neurosurgical Specialists of El Paso, PLLC** any insurance or other third-party benefits available for health care services provided to me. I understand **Neurosurgical Specialists of El Paso, PLLC** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Neurosurgical Specialists of El Paso, PLLC**, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. \_\_\_\_\_(Patient or Guardian Initials)

**Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide, if any, in applying for payment under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Neurosurgical Specialists of El Paso, PLLC** by the Medicare or Medicaid program.

5. \_\_\_\_\_(Patient or Guardian Initials)

**Consent to Telephone Calls for Financial Communications.** I agree that, in order for **Neurosurgical Specialists of El Paso, PLLC**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Neurosurgical Specialists of El Paso, PLLC** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Neurosurgical Specialists of El Paso, PLLC** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. \_\_\_\_\_(Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X \_\_\_\_\_ Date \_\_\_\_\_



**Bratislav Velimirovic, MD**

If you are not the Patient, please identify your Relationship to the Patient.  
(Circle or mark relationship(s) from list below):

- |                |                              |
|----------------|------------------------------|
| Spouse         | Guarantor                    |
| Parent         | Healthcare Power of Attorney |
| Legal Guardian | Other (please specify) _____ |



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**Notice of Form Fee**

There will be a \$20.00 charge for completion of each disability (or other) forms, which is due at the time the form is brought into the office. Please allow 1 week from the time the form is brought in (and/or the time of the last office visit) for completion of the form so that the insurance clerk has all the necessary information to complete the form.

**Thank you,  
Management**

**Aviso De Cobro Para Formas**

Habra un cargo de \$20.00 para la realizacion de cada forma de discapacidad y de cualquier otra forma, que es debida en el momento en que el formulario se pone en la oficina. Por favor permita una semana desde el momento en que el formulario es traído en (y/o el momento de la ultima visita de oficina) para la realizacion de la forma para que el empleado de seguro tiene toda la informacion necesaria para llenar el formulario.

**Gracias,  
Administracion**

Signature: \_\_\_\_\_  
(FIRMA)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(FECHA)



**Bratislav Velimirovic, MD**

**Neurosurgical Specialists of El Paso, PLLC  
Dr. Bratislav Velimirovic  
(915) 633-1916**

Thank you for choosing **Neurosurgical Specialists of El Paso, PLLC**. We shall do our best to provide you with quality and courteous care of your neurological needs.

Gracias por elegir el **Neurosurgical Specialists of El Paso, PLLC**. Haremos nuestro mayor para proporcionar con calidad y amable atencion de su problema neurological.

#### **Appointment Cancellation Policy**

In order to best serve our patients, we respectfully request that appointments be kept as scheduled. Cancellations are accepted in advance of the appointment by telephone. We respectfully request 24 hour advance notice if you need to cancel your appointment.

#### **Poliza de Cancelacion de Cita**

Con el fin de servir mejor a nuestros pacientes, solicitamos respetuosamente que se mantengan las citas como estaba previsto. Las cancelaciones se aceptan antes de la cita por telefono. Respetuosamente solicitamos las 24 horas de antelacion si necesita cancelar su cita.

#### **Medication Refill Policy**

A 48 hour notice is needed for refill of medication. If appointments have been missed or cancelled or treatment is not current, medication may not be renewed. Pain medication needs to be filled from your Primary Physician or your Pain Management Physician. Medication will not be renewed when requests are called to the answering service after office hours or on weekends and holidays.

#### **Poliza de Repuesto de Medicamentos**

Un aviso de 48 horas es necesaria para el respuesto del medicamento. Si las citas se han perdido o cancelado o tratamiento no es actual, no se podra renovar su medicamento. No se renovara la medicacion cuando se llaman a las solicitudes para el servicio de contestadores despues de horas de oficina o en los fines de semana y dias festivos.

Signature: \_\_\_\_\_  
(FIRMA)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(FECHA)



Bratislav Velimirovic, MD

**Neurosurgical Specialists of El Paso, PLLC**  
**General Consent for Care and Treatment**

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_

Signature of Patient or Personal Representative

\_\_\_\_\_

Date

\_\_\_\_\_

Printed Name of Patient or Personal Representative

\_\_\_\_\_

Relationship to Patient

\_\_\_\_\_

Printed Name of Witness

\_\_\_\_\_

Employee Job Title

\_\_\_\_\_

Signature of Witness

\_\_\_\_\_

Date



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**Bratislav Velimirovic, MD**

**Medical Questionnaire**

**Patient Name:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

M     F

**Today's date:** \_\_\_\_\_

**Chief complaint:** \_\_\_\_\_  
\_\_\_\_\_

Referring doctor: \_\_\_\_\_

Primary care doctor: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS/CONDITION**

Were you in a motor vehicle accident?    **Yes**    **No**

Were you injured at work?    **Yes**    **No**

Please describe the problem, how did it happen? \_\_\_\_\_  
\_\_\_\_\_

**How bad is it? (1 to 10)** \_\_\_\_\_    **How long have you had this?** \_\_\_\_\_    **When does it get worse/better?** \_\_\_\_\_

**What makes it get worse?**    standing    sitting    lying down    walking    bending    exercise

**What helps it get better?**    Pain reliever    rest    heat/ice    exercise    physical therapy

**Do you have any problems controlling your bladder or bowel?**    Yes    No        **Have you had back or neck surgery?**    Yes    No

**Have you had steroid injections?**    Yes    No        **What diagnostic tests have you had done?**    MRI    CT    X-ray    EMG/NCV

**WORK HISTORY**

Employer: \_\_\_\_\_    Occupation: \_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_

**CONDITIONS - Check (✓) YES OR NO the conditions you currently have or have had in the past year**

Y	N		Y	N		Y	N		Y	N	
		Alcoholism			Chemical dependency			Hepatitis			Pneumonia
		Anemia			Diabetes			Injuries			Prostate problems
		Anesthesia complications			Epilepsy			Hypertension			Rheumatic arthritis
		Arthritis			Fibromyalgia			Kidney disease			Seizures
		Asthma			Gout			Liver disease			Stroke
		Bronchitis			Headaches			Migraines			Thyroid disorder
		Cancer			Heart Disease			pacemaker			

**PAST SURGICAL HISTORY: List surgeries you have had and what year**

1.	3.
2.	4.

**MEDICATION: List medication you are currently taking, (including vitamins and herbs)**

1.	5.
2.	6.
3.	7.
4.	8.





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ALLERGIES: To medication or substances
1.
2.
3.
4.
Social History: Check (✓) the substance you use and describe how much you use.
Family History: List any illnesses that run in your family.
Caffeine Yes [ ] No [ ] How much:
Tobacco Yes [ ] No [ ] How much:
Alcohol Yes [ ] No [ ] How much:
Other \_\_\_\_\_ Yes [ ] No [ ] How much:

SYMPTOMS - Check (✓) YES OR NO the symptoms you currently have or have had in the past year.

General
Y N
Chills
Dizziness
Fainting
Fever
Loss of Weight
Numbness
Sweats

Eye, Ear, Nose, Throat
Y N
Bleeding Gums
Blurred vision
Crossed eyes
Difficulty swallowing
Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistent cough
Ringing in the ears
Sinus Problems

Cardiovascular
Y N
Chest pain
high blood pressure
Irregular heart beat
Low blood pressure
Poor circulation
Rapid heart beat
Swelling in ankles

Respiratory
Y N
Cough
Shortness of breath
Decreased in exercise capacity

Gastrointestinal
Y N
Abdominal pain
Appetite poor
Bloating
Bowel changes
Constipation or diarrhea
Gas
Heartburn or indigestion
Hemorrhoids
Nausea or vomiting

Genitourinary
Y N
Blood in urine
Frequent urinating
Lack of bladder control
Painful urination

Muscle/Joint/Bone
Pain, weakness, or numbness:
Y N
Arms
Back
Feet
Hands
Hips
Legs
Neck
Shoulders

Skin
Y N
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sore that won't heal

Neurological
Y N
Dizziness
lightheadedness
Weakness
Fainting
Seizures

Psychiatric
Y N
Depression
Headache
Loss of sleep
Nervousness
Stress
Trouble concentrating

Endocrine
Y N
Diabetes
Hypertension
Thyroid disease

Hematological
Y N
Anemia
Bleeding disorder

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any member of this staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_
Physician Signature \_\_\_\_\_

Date \_\_\_\_\_
Date reviewed \_\_\_\_\_

Physician: \_\_\_\_\_



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System/Body Area	**Elements of Examination
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>Exam of carotid arteries (e.g. pulse amplitude, bruits)</li> </ul>
	<ul style="list-style-type: none"> <li>Auscultation of heart with rotation of abnormal sounds and murmurs.</li> </ul>
	<ul style="list-style-type: none"> <li>Exam of peripheral vascular system by observation (e.g. swelling, varicosities) and palpation (e.g. pulses, temperature, edema, tenderness)</li> </ul>
<b>Constitutional</b>	<ul style="list-style-type: none"> <li>Measurement of any 3 of the following vital signs: blood pressure, pulse, respiration, temperature, height, weight.</li> </ul>
	<ul style="list-style-type: none"> <li>General appearance of patient (e.g. development, nutrition, deformities, attention to grooming)</li> </ul>
<b>Eyes</b>	<ul style="list-style-type: none"> <li>Ophthalmoscopic exam of optic discs (e.g. size, C/D ratio, appearance) and posterior segments (e.g. vessel changes, exudates, hemorrhages)</li> </ul>
<b>Musculoskeletal</b> (includes extremities)	<ul style="list-style-type: none"> <li>Exam of gait and station</li> </ul>
	<p><b>Assessment of motor function including:</b></p> <ul style="list-style-type: none"> <li>Muscle strength in upper and lower extremities</li> </ul>
	<ul style="list-style-type: none"> <li>Muscle tone in upper and lower extremities (e.g. flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (e.g. fasciculation, tardive dyskinesia)</li> </ul>
<b>Neurological</b>	<p><i>Evaluation of higher integrative functions including:</i></p> <ul style="list-style-type: none"> <li>Orientation to time, place and person</li> </ul>
	<ul style="list-style-type: none"> <li>Recent and remote memory</li> </ul>
	<ul style="list-style-type: none"> <li>Attention span and concentration</li> </ul>
	<ul style="list-style-type: none"> <li>Language (e.g. naming objects, repeating phrases, spontaneous speech)</li> </ul>
	<ul style="list-style-type: none"> <li>Fund of knowledge (e.g. awareness of current events, past history, vocabulary)</li> </ul>
	<p><b>Test the following cranial nerves:</b></p> <ul style="list-style-type: none"> <li>2nd through 12 cranial nerve</li> </ul>
	<ul style="list-style-type: none"> <li>Examination of sensation</li> </ul>
	<ul style="list-style-type: none"> <li>Examination of deep tendon reflexes in upper and lower extremities with notation of pathologic reflexes</li> </ul>
	<ul style="list-style-type: none"> <li>Test coordination</li> </ul>

**RADIOLOGIC STUDIES:**

**MDM:**

Physician: \_\_\_\_\_



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Rate the severity of your pain on this scale (*Circle One*):

1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
(1 = mild and 10 = intense/severe/worst pain of your life)

DOCTOR OR ASSISTANTS NOTES ONLY:

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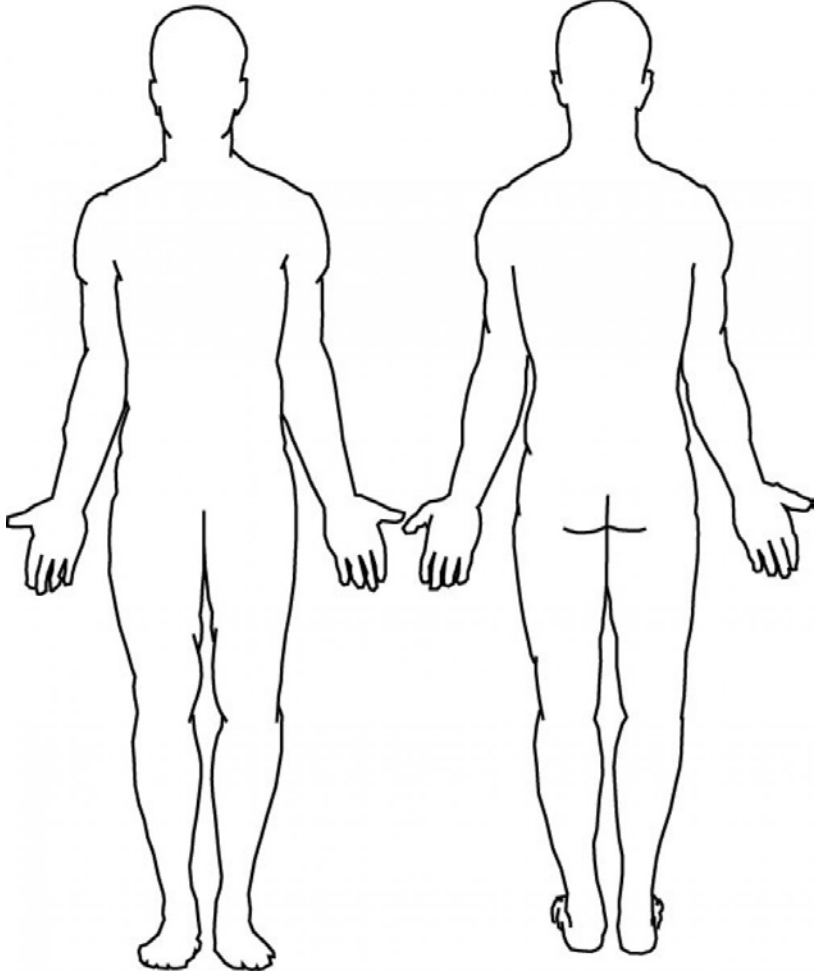
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Toe/Heel + --- SLR + --- RLE LLE ELE