

Mid – Missouri Neurosurgery
1605 East Broadway, Ste 100
Columbia, MO 65201
Phone: 573-815-8242
Fax: 573-815-8245

- 1) Please complete the enclosed paperwork and **return it to our office in the enclosed envelope** (if you did not receive an envelope, please bring the completed paperwork to your appointment). If you do not mail your paperwork back, please arrive 30 minutes prior to your appointment time in order to process your paperwork.
- 2) Bring your insurance card and photo ID to your appointment.
- 3) If your appointment is related to worker's compensation, motor vehicle accident or litigation please contact our office as we need additional information prior to your appointment.
- 4) **You MUST bring your radiology films (CT Scans, MRI scans, CT myelogram, X-rays, etc.) to your appointment. Dr. Bondurant will be unable to evaluate you without your films.** Films done at Boone Hospital Center can be viewed on our computer, and therefore you do not need to bring films that were done at Boone Hospital Center.
- 5) **Any copay or coinsurance is due at the time of service.** We accept cash, check, MasterCard, Visa and Discover card.
- 6) If you do not plan to keep this appointment, please give our office 24 hours notice prior to the appointment.

We look forward to meeting you. Please call our office at 573-815-8242 with any questions or concerns.

Date: _____

OFFICE REGISTRATION FORM

Full Name: _____ Male ___ Female ___ Age: _____

Birthdate: _____ Social Security #: _____

Race: _____ Single / Married / Widowed / Divorced

Mailing Address: _____ Telephone: (____) _____

City: _____ State: _____ Zip Code: _____ Cell Phone: (____) _____

Occupation: _____ Employed By: _____ Phone: (____) _____

Name of Spouse: _____ Birthdate: _____

Employed By: _____ Work Phone: (____) _____ Cell Phone: (____) _____

If Minor, Parent/Guardian Name: _____

Name of Contact Person: _____ Relationship: _____

Phone: (____) _____ Cell/Work Phone: (____) _____

Referring Physician: _____ Phone: (____) _____

Family Physician: _____ Phone: (____) _____

Other Treating Physicians: _____

I AUTHORIZE YOU TO COMMUNICATE WITH MY SPOUSE AND/OR CONTACT PERSON REGARDING MY MEDICAL CARE. I AUTHORIZE DISCLOSURE OF MY MEDICAL RECORDS TO THE ABOVE NAMED PHYSICIANS.

X _____
Patient or Guardian Signature

Primary Insurance: _____ Policy Holder's Name: _____

Policy Holder's Birthdate: _____ Policy Holder's Social Security #: _____

Policy/Member ID: _____ Group Number: _____

Medical Claims Address: _____

Secondary Insurance: _____ Policy Holder's Name: _____

Policy Holder's Birthdate: _____ Policy Holder's Social Security #: _____

Policy/Member ID: _____ Group Number: _____

Medical Claims Address: _____

OFFICE REGISTRATION FORM

Personal Medical History

Patient Name: _____ Birthdate: _____

Surgery (operation type/description and date)

Date: _____ Operation: _____ Date: _____ Operation: _____

Date: _____ Operation: _____ Date: _____ Operation: _____

Date: _____ Operation: _____ Date: _____ Operation: _____

Date: _____ Operation: _____ Date: _____ Operation: _____

Date: _____ Operation: _____ Date: _____ Operation: _____

Other Hospitalizations (description of admission and date)

Date: _____ Problem: _____ Date: _____ Problem: _____

Date: _____ Problem: _____ Date: _____ Problem: _____

Medical Problems (check all that apply and explain in space provided)

Heart Attack _____ Cancer _____

Heart Failure _____ Gout _____

Heart Valve Disease _____ Diabetes _____

Heart Rhythm Disease _____ Cholesterol _____

Asthma _____ Lupus _____

Emphysema _____ Pituitary Disease _____

Other Lung Disease _____ Thyroid Disease _____

Kidney Failure _____ Breast Disease _____

Other Kidney Disease _____ Bone Disease _____

High Blood Pressure _____ Infection _____

Acid Reflux _____ HIV/AIDS _____

Ulcer _____ Common Arthritis _____

Colon Disease _____ Rheumatoid Arthritis _____

Hepatitis _____ Other Arthritis _____

Other Liver Disease _____ Headache _____

Anemia _____ Stroke _____

Bleeding Disease _____ Seizure/Convulsion _____

Mental Illness _____ Eye Disease _____

Blood Disease _____ Skin Disease _____

Osteoporosis _____

Preferred Pharmacy (name and location): _____

OFFICE REGISTRATION FORM

Patient Name: _____ Birthdate: _____

Medications: (CURRENT scheduled, as needed, non-prescription, vitamin, supplement, herbal & experimental, attach additional page if needed)

Medication Name	Prescribed Dose	Directions for taking the medication

Medication Allergies (describe reaction)

___ No Known Drug Allergies

Medication	Reaction to the medication

Do you currently use/have you used any of the following:

Tobacco, of Any Kind?	Yes	No	How Much? _____	Quit Date: _____
Alcohol?	Yes	No	How Much? _____	Quit Date: _____
Illicit Drugs?	Yes	No	What Kind? _____	Quit Date: _____

Do you have any diseases that run in your family (circle all that apply)?

Kidney	Heart	Lung	Diabetes
Cancer	High Blood Pressure	Aneurysm	Birth Defect
Bleeding	Skin	Eye	Brain
Spine	Nerves	Arthritis	Anesthesia Difficulty
Connective Tissue	Other: _____		

What do you do for daily activity (employment or non-employment)?

Have you recently realized any trouble with (circle all that apply)?

Nausea Vomiting Sweats Chills Diarrhea Constipation Cough Fever Flu Chest Pain
 Palpitation Shortness of Breath Passing Out Seizure/Convulsion Abdomen Pain Weight Change
 Urine Retention Rash Bone/Muscle/Joint Pain Blood in Urine/Stool/Cough/Vomit Headache
 Vision Change Hearing Change Dizziness Hoarseness Swallowing Trouble Bruising Numbness
 Tingling Weakness Clumsiness Menstruation Problem Loss of BOWEL or BLADDER control

What problem(s) are we meeting to discuss?



- PARKING**
- 1** Anthony / Ann Lot
 - 2** Visitor Lot
 - 3** Anthony / William Lot
 - 4** Bass / William / Snodley Lot
 - 5** Main Entrance Lot
 - 6** William St. Parking Garage
 - 7** Pain Mgmt. Lot
 - 8** Nifong Lot
 - 9** BMP 1 Lot
 - 10** Jack Estes Way Lot
 - 11** BMP 2 Lot
 - 12** BMP Parking Garage
 - 13** BMP 4 Lot
 - 14** BMP 3 Lot
 - 15** Physician Parking
 - 16** Emergency / Physicians Parking
 - 17** Doctor's Bldg. Lot

- LEGEND**
- Hospital
 - Parking Garages
 - Surface Parking
 - Additional Boone Services

- ENTRANCES / BUILDINGS**
- ★ **Hospital Main Entrance**
 - A** Doctor's Building
 - B** William St. Parking Garage Entrance
 - C** Nifong Entrance
 - D** Administration Entrance
 - E** North Loading Dock
 - F** Family Birthplace Entrance
 - G** Pain Clinic Entrance
 - H** Outpatient Services Entrance
 - J** South Loading Dock
 - 1** Broadway Medical Plaza (BMP) 1
 - 2** Broadway Medical Plaza (BMP) 2
 - 3** Broadway Medical Plaza (BMP) 3
 - 4** Broadway Medical Plaza (BMP) 4

How to Get to Boone Hospital Center

1600 E. Broadway
Our hospital is located at the intersection of East Broadway and William Street in Columbia, Mo, with easy access from Highway 63, Interstate 70 & downtown Columbia.

Our four Medical Plaza buildings, 1601, 1605, 1701 and 1705 E. Broadway are located just north of the hospital.

Parking

For your convenience, Boone Hospital Center provides shuttle vans running continuously in all visitor parking lots. These white vans will pick you up, take you directly to the main entrance of the hospital and return you to your car after your visit. We also provide covered parking in the William Street Parking Garage with a covered walkway to the hospital.

We have maps for visitor and patient parking, employee parking and medical offices. You may also create custom driving directions to Boone, courtesy of Google Local.

Contact Us

The Boone Hospital Center main phone number is (573) 815-8000 & fax number is (573) 815-2492. This line can be used for general questions as well as finding a patient's room number.

For all medical records requests, call (573) 815-7010. For bill or payment information, call (573) 815-3305. To find a physician, call (573) 815-6400.

Boone Hospital Center continues to strive to better the quality of life for our patients, visitors and staff. To be consistent with that aim, the hospital has implemented a no-smoking policy to provide a safe and toxin-free environment. Smoking is not permitted in the hospital or in buildings owned by the hospital.