Northeastern Migraine
SURGERY CENTER
a division of Bangor Plastic and Hand Surgery

General Patient Information

Dr. David A. Branch, M.D.

****Please Print****

Patient Name: _____

Date of Birth: _____ Social Security # _____

Email Address_____

Patient Address_____

City:_____State:_____Zip Code: _____

Phone_____Marital Status: S _M _W _D___

Emergency Contact_____Emergency Contact Phone_____

Referring Physician_____Phone Number_____

Address_____

Primary Care Physician_____Phone Number_____

Address_____

Neurologist_____Phone Number_____

Address_____

Name of Insurance Company_____

Address_____

Policy Number_____Group Number_____

Provider /Customer phone number from back of card_____

Secondary Insurance_____

Address_____

Policy Number_____Group Number_____

Provider /Customer phone number from back of card_____

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Past Medical History: Check all that apply. Write detailed explanation for yes answers

Health Problem:

- ☐ Heart Problems? _____
- ☐ High Blood Pressure?_____
- ☐ Low Blood Pressure? _____
- ☐ High Cholesterol? _____
- ☐ Blood Vessel/Clotting Problems? _____
- ☐ Neurological Problems? Stroke/ Seizures? _____
- ☐ Lung Problems? _____
- ☐ Kidney Problems? _____
- ☐ Diabetes? Type? _____
- ☐ Thyroid Problems? _____
- ☐ Liver Problems? _____
- ☐ Bleeding Problems? _____
- ☐ Muscular Skeletal Problems? _____
- ☐ Problems with Anesthesia? _____
- ☐ Do you wear dentures, caps, crowns? _____
- ☐ Do you experience voiding problems? _____
- ☐ Have you had Shingles, Cold Sores or Herpes? _____
- ☐ Other? _____

Allergies to Medications/reaction: _____

_____

Current Medications/why you are taking them?_____

_____

_____

_____

Past Surgeries?

Procedure:_____Date: _____

Procedure:_____Date: _____

Procedure:_____Date: _____

Procedure:_____Date: _____

Social History:

Do you smoke?_____How Much?_____How Many Years? _____

Occupation_____

Do you regularly drink alcohol or beer? How much? _____

Do you have trouble hearing?_____Speaking? _____

Do you follow a special diet? _____

Family History?

Please list all serious health issues or conditions that run in your family, and who the affected family member is._____

_____

_____

Review of Systems:

Have you had any recent problems with the following?

- ☐ Abnormal menstruation
- ☐ Back pain
- ☐ Black out spells
- ☐ Chest pain
- ☐ Cough
- ☐ Difficulty urinating
- ☐ Eye dryness
- ☐ Skin rashes
- ☐ Irregular heart beat
- ☐ Limits of jaw motion
- ☐ Motion sickness

Current Height/Weight:

Weight_____Height _____

Women only this section:

Are you pregnant?_____Date of your last menstrual period _____

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment.

I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges not covered by my insurance.

Signature:_____Date: _____

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Please use this Migraine Pain Scale to answer the questions below.
Be as specific as possible when describing your Migraine Pain

0- Pain Free

1- Very minor annoyance- mild aches to parts of the body. No medication needed.

2- Minor annoyance- dull aches to parts of the body. No medication needed. Able to go to work or volunteer each day. Normal daily activities. Maintains social life and family life outside of work.

3- Annoying enough to be distracting. Pain requires over-the-counter remedies. Able to work 8 hours and maintain family and social activity but slightly limited or altered.

4- Pain can be ignored if you are really involved in your work but still distracting. Can work for 6 hours daily. Still have energy to make plans for one evening socially during the week. Active on weekends.

5- Pain cannot be ignored for more than 30 minutes. Can work for 5 hours per day. Can make plans to do simple activities on weekends. Pain not controlled with over-the-counter remedies.

6- Pain cannot be ignored for any length of time. Still able to function at work 4 hours daily. Pain medication required more than once in 24 hours. Takes part in limited social activities on weekends.

7- Pain makes it very difficult to concentrate. Pain interferes with sleep. Struggles to fulfill daily activities at home. Unable to work or volunteer. No outside social activities.

8- Physical activity severely limited. Able to read and converse with effort. Sleep in late, able to get dressed by noon, minimal activities at home. Contact with friends and family via phone or email. Stay home all day.

9- Non-functional for all practical purposes. Cannot concentrate. Physical activity halted. Stay in bed more that half the day. No contact with outside world. Panic sets in.

10- Totally non-functional. Unable to speak. Crying out or moaning. Stay in bed all day. Feeling helpless and hopeless about life.

NEMS

Pre-treatment Migraine Questionnaire

Patient Name: _____ Date: _____

DOB: _____ Occupation: _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed ___

Race: Caucasian_____ Hispanic_____ African American ____ Other_____

Education Level: HS Grad ___ 2 Yr. degree ___ 4 Yr. degree ___Advanced degree ____

1. How old were you when your migraine headaches started? _____
2. Do any of your family members have migraine headaches? Who? _____
3. How many migraine headaches do you experience per month (on average)? _____
4. How painful are your migraine headaches without medication? (on a scale from 1-10, 1 being mild, 10 being severe?) 1 2 3 4 5 6 7 8 9 10
5. How long do your migraines last without medication (on average)?

   No more than 2 hrs ___ 3-4 hrs. ___ 5-12hrs ___ 12-24___ several days ___
6. With migraine medicine how long do your migraine headaches last?

   No more than 2 hrs ___ 3-4 hrs. ___ 5-12hrs ___ 12-24___ several days _
7. How painful are your migraine headaches with medication? (on a scale from 1-10, 1 being mild, 10 being severe?) 1 2 3 4 5 6 7 8 9 10
8. How many regular (background) headaches do you have per month? (on average) ___
9. How painful are your regular (background) headaches? (on a scale from 1-10, 1 being mild, 10 being severe?) 1 2 3 4 5 6 7 8 9 10
10. How long do your regular (background) headaches last?

    No more than 2 hrs ___ 3-4 hrs. ___ 5-12hrs ___ 12-24___ several days _
11. How many times in the last month have you had nausea_____ vomiting _____

12. Where is your migraine headaches usually located?

above right eye brow ____ above the ear _____ Left temple ____ Back of head right _____

behind the left eye _____ above the left eyebrow ____ behind the ear _____ into jaw _____

back of head left _____ behind right neck ____ in front of ear _____ Right temple _____

into Cheek ____ behind the right eye ____

13. Where do your migraine headaches usually start? _____

14. How would you describe your migraine headaches?

Throbbing/pounding _____ Ache/pressure _____ like a tight band _____

Dull _____ Sharp _____

15. Do any of the following occur before/during your migraine headaches?

☐ Nausea	☐ Vomiting	☐ Diarrhea
☐ Bothered by light and noise	☐ Blurred/double vision	☐ Loss of vision
☐ Eyelid puffy	☐ Eyelid droops	☐ Tingling
☐ Feeling light headed	☐ Numbness	☐ Flashing lights
☐ Runny nose	☐ Speech difficulty	☐ Weakness
☐ Loss of consciousness		

16. Do any of the following make your migraine headaches better?

☐ Rest	☐ Hot/cold compress	☐ Pressure over migraine site
☐ Exercise	☐ Massage	☐ Other _____
☐ Quiet/darkness	☐ Warm shower	_____

17. Do any of the following bring on your migraine headaches or make them worse:

☐ Stress ☐ Loud noise ☐ Straining/bending over ☐ Alcohol

☐ Bright sunshine ☐ Fatigue ☐ Sexual activity ☐ Other _____

☐ Weather change ☐ Certain smells ☐ Heavy lifting

☐ Let down (after stress) ☐ Missed meals ☐ Certain foods

☐ Air travel ☐ Coughing ☐ Seasonal allergies

18. If you are a female, do your migraine headaches change with the following?

☐ Menstrual cycle ☐ Birth control pills ☐ Pregnancy ☐ Hormone

☐ Supplements

19. Have you ever been diagnosed with any health disorders? _____

_____

20. Have you had your migraine headaches evaluated by a neurologist? If so, when, where, and by whom? What was the diagnosis given? _____

_____

_____

21. List all past tests you have had for your migraine headaches: _____

_____

22. List any/all past treatments for your migraine headaches: _____

_____

23: check all medication you **have** taken to treat your migraine headaches:

Anti-inflammatory:

☐ Aspirin ☐ Advil ☐ Toradol ☐ Tylenol ☐ Excedrin

☐ Prednisone ☐ Dexamethasone ☐ Cortisol

Narcotics:

☐ Fiorinal ☐ Vicodin ☐ Percocet ☐ Demerol ☐ Oxycontin

☐ Oxycodone ☐ Dilaudid ☐ Hydrocodone ☐ Fioricet

Abortive:

☐ Cafegot ☐ Relpax ☐ Treximet ☐ Maxalt ☐ Amerge

☐ Frova☐ Zomig ☐ Midrin ☐ Sumatriptan ☐ Imitres

Preventative:

☐ Propranolol ☐ Timolol ☐Nadolol ☐ Metoprolol ☐Atenolol

☐ Verapamil ☐ Diltazem ☐ Amitriptyline ☐ Nortriptyline

☐ Topiramate ☐ Elavil ☐ Topamax Clonidine ☐Feverfew

☐ Dilantin ☐ Depakote ☐ Zoloft ☐ Paxil ☐ Prozac

☐ Effexor ☐ Wellbutrin ☐ Trazodone ☐ Protriptyline ☐ Desipramine

☐ Doxepin ☐ Other _____

Miscellaneous:

☐ Phrenilin ☐ DHE ☐ Baclofen ☐Gabapentin ☐ Cymbalta

24. List **current** medications you are taking to treat your migraine headaches:

_____

_____

_____

25. In the last month, how many times have you taken the prescribed medications?

_____

26. Are you taking any over the counter medications to treat your migraine headaches?

_____

If yes, list medications and how often you are taking them:

_____

27. What is the estimated cost per month for your migraine headache medication visits to ER/doctor's office? _____

28. How much of these medical expenses are covered by your health insurance?

_____

29. How would you rate your general health in the last month?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

30. To what extent do migraine headaches affect your quality of life?

☐ Not at all ☐ Very little ☐ Moderately ☐ Fairly significantly ☐ Extremely

31. How many times in the last year, have you been to the Emergency Room for treatment of your migraine headaches? _____

32. Do your migraine headaches wake you at night? _____

33. Do you wake in the morning with a migraine headache? _____

Nasal Evaluation

1. Have you ever had nasal trauma or surgery? _____
2. Do you have breathing difficulties from either nostril? _____
3. Do you have sleep apnea? _____
4. Do you snore? _____
5. Do you have history of sinus headaches? _____
6. Do you have a history of sinus infections? _____
7. Are you a mouth breather? _____
8. Do you get any relief with sprays, humidifiers or antihistamines? _____
9. Do you wake at night with breathing problems? _____
10. Do your migraine headaches get worse with weather changes? _____

Neck Evaluation

1. Have you ever had any neck trauma or surgery? _____
2. Does a neck massage benefit or worsen your migraine headache? _____

Pre-Treatment MIDAS Form

Directions: Complete questions 1-5 for ALL of your headaches during the last 3 months. Write "0" if you did not experience that activity in the last 3 months. Add up the answers to questions 1-5

1. How many days in the last 3 months did you **miss work or school** because of your headaches?_____

2. How many days in the last 3 months was your productivity at work or school been reduced by half or more because of headaches? (Do not include days you counted in question 1 where you missed work or school.)_____

3. How many days in the last 3 months did you NOT do housework because of your headaches? _____

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches: (DO not include days you counted in ques6on 3 where you did not do household work)_____

5. How many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?_____

TOTAL: Add the total number of days from questions 1-5

TOTAL :_____

Patient Name _____ Date _____

REQUEST FOR PATIENT MEDICAL RECORDS

Patient Name: _____/_____
Last First MI DOB:

Address: _____

Date of Birth: _____SS#_____

Person/Practice requesting information:_____

Information requested from:

Name:_____

Address:_____

Phone #_____

Information to be disclosed:

Periods of treatment from _____to_____

_____Complete Medical Records _____Partial Medical Records; Specify_____

Is information regarding mental health, any HIV- related condition (including HIV-related test, illness, AIDS or any other information indicating potential exposure to HIV) or drug and alcohol use being requested?

_____YES_____NO

Date the information is needed: _____

Patient Signature _____Date_____

Witness Signature _____Date_____

As a covered entity under HIPPA Bangor Plastic and Hand Surgery, is aware that this information may not be re-disclosed, unless permitted to do so under the state or federal law. Bangor Plastic and Hand Surgery certifies that any patient authorizations attached are valid, to the best of its knowledge, and that the information requested is the minimum amount necessary to accomplish the specific purpose.

_____ _____
Print Name of North Eastern Migraine Surgery Center Staff Member Date

BILLING AND PAYMENT OPTION FOR MIGRAINE SURGEY

All migraine surgery patients will receive an estimate for the cost of their proposed surgery. Dr. Branch's estimate is guaranteed for six (6) months. Dr. Branch is not a participating provider with any insurance companies. Our billing department will, however, work with all insurance companies even though we remain out of network with private insurance.

Payment for Dr. Branch's fee is required **14 business days prior to surgery**. The patient then can submit to their insurance company for reimbursement. A pre-certification with your insurance company will be done through our office for you, to determine coverage for Dr. Branch's fee. If there is a denial from your insurance company, you may be asked to pay the entire surgery fee upfront, including surgeon, facility and anesthesia.

The surgery center and anesthesia department will bill your insurance directly for services rendered, unless there is a denial from the insurance company. Please be aware that you will be balance billed by the surgery center or anesthesia department if you're deductible and coinsurance have not been met.

CARE CREDIT OPTION

Care Credit is a revolving credit card. It is designed to cover expenses traditional insurance would not cover. Care Credit may be used at participating offices.

You can go to **www.bangorplastic.com** and apply through the Care Credit link, or you may apply in our office with the Patient Coordinator.

You will get an immediate decision, and if you are accepted, a credit limit. We can ask for credit limit increases here through our office if need be.

Please be aware that Northeastern Migraine Surgery Center participates with five Care Credit Payment Options: 6 Months,/No Interest, or extended pay options including 24 Months/14.9% Interest, 36 Months/14.9% Interest, 48 Months/14.9% Interest and 60 Months/14.9% Interest.