Account #_______________

PATIENT REGISTRATION

Please answer all questions completely. **PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED**

Date____________________________ ☐**New** ☐**Update**

Name____ Date of Birth ______________ ☐ Male
Last First Middle ☐ Female

Home Address________________________

City/State/Zip ________________________

Phone (_____) ____________________________

Cell (_____) ______________________________

Race __White/Caucasian __ Black or African American __ Asian
__ American Indian __ Native Hawaiian or Other Pacific
__ Decline to State

Ethnicity __ Hispanic or Latino __ Not Hispanic or Latino
__ Decline to State

Primary Language Spoken ______________________________

Patient's Soc. Sec. # ________________________

Driver License No/State ______________________

Employer_________________________ Employer's Address____

Who is your Primary Care Physician? ____________________________Referring Physician? ______________________

PATIENT'S E-MAIL ADDRESS ____

Financially Responsible Party (subscriber info)

If other than self ____Relationship ________________

Address ____ Phone (__)______________
Number Street City

Patient's Primary Insurance ___________________________ **Subscriber's Social Security #**__________________

Subscriber ID #__________________________**Subscriber's Group ID#** _____________________**DOB** ____/____/____

Patient's Secondary Insurance ______________________________ **Subscriber's Social Security #**_________________

Subscriber ID #_________________________ **Subscriber's Group ID#** _____________________ **DOB** ____/____/____

Subscriber to Secondary Insurance ____________________**Relationship to Patient**__________________

Emergency contact____ Relationship ____________
Last Name First Middle

☐ **Please check box if authorized to release appointment/medical information.**

Address ____ Phone (_______)______________
Number Street City

I have read and understand all of the above and hereby give my consent for medical treatment.

I understand that I am responsible for my bill.

I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.

____ ________________________

Patient's Signature **Date**

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Account #________________

PERMISSION TO FURNISH MY MEDICAL INFORMATION

Patient Name: ________________________________

1. <u>FURNISH TO RELATIVES AND/OR PERSONAL ASSOCIATES</u>

I hereby give my consent to The Neurology Center to furnish medical information about me (e.g., blood test results, other test results, doctor's instructions, etc.) in the event I am not immediately available.

Approved Person(s)	Relationship to Patient
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

- ❑ I hereby authorize The Neurology Center to disclose medical information in the purpose to contact me with routine results and to remind me of my future appointments. You may email, send text messages and or leave this information on my answering machine.
- ❑ I hereby instruct The Neurology Center to furnish information **<u>only</u>** to me. In this instance, I understand you will leave a message for me to call the office if I am not immediately available.

❑ Other special instructions regarding furnishing my medical information: ________________________

____

____

x________________________________ __________ ________________________________

Patient Signature **Date** **Designated Power of Attorney**

2. <u>FURNISH TO PHYSICIANS OR OTHER MEDICAL PROVIDERS</u>

I understand that The Neurology Center will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc.) **about me with my Primary Care Physician and/or the Provider or entity that referred me to The Neurology Center.**

<u>In addition</u>, I hereby give my consent to The Neurology Center to furnish and/or discuss my medical information with the following additional Medical Providers or Entity(ies)

Providers Name	Phone Number	City
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

x________________________ ________________________ ________________________

Patient Signature **Date** **Designated Power of Attorney**

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Account #________________

NEW PATIENT HISTORY

Name ______________________________ **Birthdate** ___________ **Date** ___________

Age: _______ I am: ☐ Right-Handed ☐ Left-Handed ☐ Ambidextrous

Referring Physician: ____

What is your primary language spoken? ____

How do you prefer to receive information about your diagnosis? ___Verbal ___Written ___Pictures

Chief Complaint
Please list the main problems, which bring you to the doctor

1. ____

2. ____

3. ____

4. ____

Please describe the problems:

____

____

____

____

____

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Review of Symptoms

Check boxes if you are having any of these symptoms; write in details:

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Changes in Weight

Eyes
- ☐ Double vision
- ☐ Eye Pain
- ☐ Blurred vision

Ears, Nose, and throat
- ☐ Hearing loss
- ☐ Ringing
- ☐ Dizziness
- ☐ Sore throat

Cardiovascular
- ☐ Ankle swelling
- ☐ Night sweats
- ☐ Chest Pain or Pressure
- ☐ Skipped beats
- ☐ Blackouts

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Hyperventilation

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Appetite loss
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Hematologic/Lymphatic
- ☐ Easy bruising or bleeding
- ☐ Anemia

Musculoskeletal
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Joint Limitation
- ☐ Joint pain
- ☐ Neck pain
- ☐ Back pain

Genitourinary
- ☐ Blood in urine
- ☐ Burning with urination
- ☐ Hesitancy
- ☐ Nighttime frequency
- ☐ Difficulty with urination

Skin/Breast
- ☐ Rashes
- ☐ Nipple discharge

Endocrine
- ☐ Intolerant of heat or cold
- ☐ Excessive urination
- ☐ Excessive hunger
- ☐ Increased thirst

Allergic/Immunologic
- ☐ Allergies to medication, Iodine, shellfish,

Neurological
- ☐ Difficulty with speech
- ☐ Impaired memory
- ☐ Confusion
- ☐ Headaches
- ☐ Seizures
- ☐ Blackouts
- ☐ Fainting
- ☐ Trouble swallowing
- ☐ Arm pain
- ☐ Leg pain
- ☐ Weakness or paralysis
- ☐ Tremors
- ☐ Incoordination
- ☐ Uncontrolled movements
- ☐ Stroke
- ☐ Imbalance
- ☐ Numbness
- ☐ Tingling

Psychiatric
- ☐ Mood swings
- ☐ Depression
- ☐ Anxiety
- ☐ Memory
- ☐ Hallucinations

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Current height _______________ Current weight _______________

Patient Name: ________________________________

Past Medical History

Check if you have had any of these problems. Give details.

- ☐ Alcoholism
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Blindness, part or full
- ☐ Cancer
- ☐ Concussion
- ☐ COPD
- ☐ Double vision
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Depression
- ☐ Diabetes
- ☐ Dementia
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Headache
- ☐ Multiple Sclerosis
- ☐ Myopathy or Muscular Dystrophy
- ☐ Neuropathy
- ☐ Parkinson's Disease
- ☐ Seizure (Epilepsy)
- ☐ Stroke
- ☐ Substance Abuse Disorder
- ☐ _______________
- ☐ _______________

Allergies:

Please list any allergies to medications ____

Are you allergic to X-ray dye? ____

Are you allergic to shellfish? ____

Medications – Please list all the medications you are currently taking. Include aspirin, birth control pills hormones, water pills, sleeping pills, tranquilizers, vitamins, etc.

Medication	Dosage	How often taken?	For how long have you taken it?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Surgical Procedures – List chronologically

Operations	Hospital & City	Date
1.		
2.		
3.		

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Patient Name: ________________________________

Other Hospitalizations or Other Medical Problems

1.	
2.	
3.	
4.	

Have you had any of these tests? Give details.

- □ Angiogram of the brain
- □ CAT scan
- □ EEG (brain wave test)
- □ EMG (nerve-muscle test)

Social History

Your place of birth: ________________________________

Marital Status: □ Married □ Single □ Divorced □ Widowed

Education Completed: (YEARS) □ 9 □10 □11 □12 □13 □14 □15 □16 □ 16+

Occupation: ________________________________

Do you exercise regularly? □ Yes □ No, if so, what do you do? ________________

Habits

Check any of the following that you have used and state amount:

□ Caffeine How much per day? ________________

□ Alcohol How much per day? ________________

□ Tobacco How much per day? ________________

Family History

Have any of your relatives has any of the following? If yes, indicate relationship (e.g., father):

Check if positive **Relationship**

□ Alcoholism ________________

□ Cancer ________________

□ Diabetes ________________

□ Heart Disease ________________

□ Mental Illness ________________

□ Migraine ________________

□ Seizures ________________

□ Stroke ________________

□ Tuberculosis________________

Are there any other diseases that run in the family?________________

Did you need any assistance filling out this form? _____Y _____N___________

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Signature ______________________________Date _______________________________

Sleep Survey

Name: ______________________________ DOB: ______________

Do you snore?	**Yes ____**	**No ____**
Do you feel tired, fatigued, or sleepy during the day?	**Yes ____**	**No ____**
Has anyone observed you stop breathing while you sleep?	**Yes ____**	**No ____**
Do you nap during the day?	**Yes ____**	**No ____**

Do you have any of the following?

Heart Disease	☐ Yes	☐ No
History of Stroke	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Morning Headaches	☐ Yes	☐ No
Trouble with Memory Or Concentration	☐ Yes	☐ No

Sleep Orders
For Office Use Only

- ☐ **Sleep Consult**
- ☐ **PSG**
- ☐ **CPAP Titration Study**

____
Physician Signature

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Pain Survey

Name: ______________________________ DOB: ______________

Do you have current or chronic neck pain? **Yes ____** **No ____**

If *Yes*, do you have a history of surgery/procedures to relieve pain? **Yes ____** **No ____**

Do you have current or chronic back pain? **Yes ____** **No ____**

If *Yes*, do you have a history of surgery/procedures to relieve pain? **Yes ____** **No ____**

Do you have any other chronic pain? Please describe ____________________________________

Are you currently seeing a doctor for pain management? **Yes ____** **No ____**

If *Yes*, what is the doctor's name? ____________________________________

_______________________________ **Was a pain consult ordered?** **Yes ____** **No ____**
Physician Signature

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