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 (______) ______________________________

Patient's Soc. Sec. # __________________________

Driver License No/State _______________________

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 ________________________________

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**

6010 Hidden Valley Road, Suite 200, Carlsbad, CA 92011
1955 Citracado Pkwy, Suite 102, Escondido, CA 92029
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15721 Pomerado Rd., Poway, CA 92064
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PERMISSION TO FURNISH MY MEDICAL INFORMATION

1. FURNISH TO RELATIVES AND/OR PERSONAL ASSOCIATES

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 **only** 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______________________ ________ ______________________
Signature **Date** **Relationship to Patient**

2. FURNISH TO PHYSICIANS OR OTHER MEDICAL PROVIDERS

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.**

In addition, 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______________________ ______________________ ______________________
Signature **Date** **Relationship to Patient**

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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 Systems

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
- ☐ Night time 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

Current height _______________

Current weight _______________

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Patient Name: ______________________________

Past Medical History

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

- ☐ Angina
- ☐ Asthma
- ☐ Blindness, part or full
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Double vision
- ☐ Fainting
- ☐ Head trauma
- ☐ Headache
- ☐ Hearing problem
- ☐ Heart attack
- ☐ Heart failure
- ☐ Hepatitis
- ☐ Herniated disc
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart beats
- ☐ Nervous breakdown
- ☐ Numbness
- ☐ Polio
- ☐ Psychiatric conditions
- ☐ Sciatica
- ☐ Seizures (epilepsy)
- ☐ Speech problems
- ☐ Stroke
- ☐ Swallowing problems
- ☐ Ulcers
- ☐ Venereal infections
- ☐ Vertigo
- ☐ Walking problems

Have you had any of these tests? Give details.

- ☐ Angiogram of the brain
- ☐ CAT scan
- ☐ EEG (brain wave test)
- ☐ EMG (nerve-muscle test)
- ☐ Spinal tap
- ☐ Skull X-ray
- ☐ Spine X-ray
- ☐ Magnetic Resonance (MRI)

Medications – Please list all of 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.	

Allergies:
Please list any allergies to medications ______________________________________

Are you allergic to X-ray dye? ______________________________________

Are you allergic to shellfish? ______________________________________

Social History
Your place of birth: ______________________________________

Martial 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___________
Signature ________________________________Date __________________________________

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Sleep Survey

Name: ________________

DOB: ____________ **Age:** ___________

Weight: ________ **Height:** ____________

Gender ☐ Female ☐ Male

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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Copy of e-signature electronic document.
Patient will be signing this document at the time of check in.

Welcome to The Neurology Center

STATEMENT OF FINANCIAL POLICY
This facility will bill your insurance and receive payment directly from them. Any services that your insurance will not cover are your responsibility. If for any reason you are not able to pay your co-payment at the time of service an additional $15.00 will be added to your statement.

If you have HMO insurance, it requires authorization for any treatment in our office. If this authorization has not been obtained before your visit, you will be required to sign a financial waiver. You will be expected to pay for all charges incurred, and If your insurance subsequently authorizes the services, your payment will be refunded upon receipt of insurance payment.

If we are not a participating provider for your insurance plan, we will bill your insurance as a courtesy, if you have provided us with complete information to do so.

If you do not have insurance, payment is expected at the time of service. We accept Visa, MasterCard and American Express for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Business Office upon your request.

If you need our doctor to complete forms such as disability or Department of Motor Vehicles, there will be a $35 fee per form to be completed.
Statements are mailed monthly to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact the Billing Office at (760) 631-3020 to make payment arrangements.

New patients: A 24-hour advanced notice is required if you must cancel or change your appointment. If you miss your initial appointment without notifying our office, we will notify your referring provider and make an attempt to schedule another appointment. If a second appointment is missed with no notification, we will ask that you be referred to another provider.

For established patients who miss an appointment without giving a 24-hour advanced notice, there is a $75.00 charge for general office visits, and a $200.00 charge for all missed diagnostic testing or study appointments. **Our policies are created to allow for effective scheduling and to ensure all patients wishing to be seen may be accommodated. Please help us better serve you by notifying us as soon as possible if you must change or cancel your appointment.**

LAB TEST, CAT SCANS, MRI'S, ETC:
When referred to an outside facility, please contact your insurance to ensure it is a contracted facility, in orders to keep your costs down. ***Ultimately, it is your responsibility to know your insurance plan benefits.***

*****Please note that our office does not call patients with normal test results. All normal test results will be reviewed during follow up office visit. If you wish to get your results prior to your next appointment please call our office at 760-631-3000 option 4.** ***

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Prescription Refills:

Please call your pharmacy for prescription refills, at least 4 to 5 days before you run out of medication. Our doctors cannot authorize refills after office hours or on weekends, as they cannot access your medical records. Refills requested after hours will be reviewed for refill, on the next business day, and may take up to 48 hours to fill. Refills can take up to 4 days if we have to request authorization from your insurance as we have to wait for the approval before we can call pharmacy.
We provide medical records to other medical providers.
The Neurology Center will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc.) **with your Primary Care Physician and/or the Provider or entity that referred you to The Neurology Center.**

HIPAA Notice of Privacy Practices – Acknowledgement of Receipt and Consent to Disclosure 14712

The Neurology Center of Southern California participates in an Organized Health Care Arrangement (OHCA) with the University of California, San Diego Health System (UCSD) for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPAA). This notice is jointly used by and jointly describes the practices of all participants with the OHCA, including, without limitation any health care professional authorized to enter information into your medical record. UCSD also has its own Notice of Privacy Practices that can be access at http://health.ucsd.edu/hipaa/Pages/hipaa.aspx.
The OHCA will follow the terms of this joint notice. The OHCA may share medical information with each other for treatment, payment, or health care operations related to the OHCA as well as for research related purposes conducted at UCSD and at all related UC Medical Groups and UC Hospitals."

I have read and understand The Neurology Center's financial and claims filing policies.
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 and consent to having my insurance payor billed.
I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.

____

Patient's Signature or Responsible Parties Signature

Thank you for choosing The Neurology Center!

09/18

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