



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 _____

Employer _____ Employer's Address _____

Who is your Primary Care Physician? _____ Referring Physician? _____

PATIENT'S E-MAIL ADDRESS _____

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 _____

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



PERMISSION TO FURNISH MY MEDICAL INFORMATION

Patient Name: _____

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



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:

Multiple horizontal lines for describing problems.

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

Current height _____

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 weight _____

Patient Name: _____

Past Medical History

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

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

Have you had any of these tests? Give details.

- | | |
|--|---|
| <input type="checkbox"/> Angiogram of the brain | <input type="checkbox"/> Spinal tap |
| <input type="checkbox"/> CAT scan | <input type="checkbox"/> Skull X-ray |
| <input type="checkbox"/> EEG (brain wave test) | <input type="checkbox"/> Spine X-ray |
| <input type="checkbox"/> EMG (nerve-muscle test) | <input type="checkbox"/> 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.		

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: _____

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 _____

Signature _____ Date _____



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

<p>Sleep Orders For Office Use Only</p> <p><input type="checkbox"/> Sleep Consult</p> <p><input type="checkbox"/> PSG</p> <p><input type="checkbox"/> CPAP Titration Study</p>

Physician Signature