



# 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

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

Three horizontal lines for entering the approved person's name.

Three horizontal lines for entering the relationship to the patient.

- Three checkboxes for authorizing disclosure, instructing to furnish information only, and other special instructions.

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

Three horizontal lines for provider name.

Three horizontal lines for phone number.

Three horizontal lines for city.

X Signature

Date

Relationship to Patient





**Sleep Medicine Questionnaire (continued...)**

Was sleep apnea diagnosed?    Yes    or    No

If yes, please describe: \_\_\_\_\_

Are you on CPAP?            Yes    or    No    If yes, What is your pressure setting? \_\_\_\_\_

**Are you currently having any of the following problems? Circle all that apply.**

***Constitution***

- Fever
- Chills
- Weight gain/loss

***Eyes***

- Blurred/double vision
- Floaters
- Eye pain

***Ears, Nose, Throat***

- Hearing loss
- Ringing in the ears
- Congestion
- Imbalance
- Difficulty swallowing

***Cardiovascular***

- Chest pain
- Irregular beats
- Swelling in legs

***Respiratory***

- Coughing
- Wheezing
- Short of breath

***Skin***

- Rash
- Hives
- Pain
- Itching

***Endocrine***

- Excessive thirst
- Sweating
- Too hot/cold

***Neurologic***

- Headache
- Numbness/tingling
- Dizziness
- Seizures
- Loss of consciousness
- Sudden muscle weakness with strong emotion

***Psychological***

- Mood problems
- Depression
- Anxiety
- Increased life stressors
- Crying spells
- Thoughts of suicide

***Gastrointestinal***

- Nausea, vomiting, heartburn, constipation,
- Diarrhea, stomach pain, blood in stool

***Genitourinary***

- Frequent urination
- Incontinence
- Painful urination
- Bleeding with urination
- Decreased sex drive or impotence
- Menstrual problems

***Musculoskeletal***

- Pain in muscles/joints
- Swelling in joints
- Weakness
- Leg movements before/during sleep
- Recent falls



## Sleep Medicine Questionnaire (continued...)

**Medical History – circle all that apply.**

- |                                       |                 |                         |
|---------------------------------------|-----------------|-------------------------|
| Atrial fibrillation                   | Depression      | Coronary artery disease |
| Insomnia                              | Heart failure   | Stroke/TIA              |
| High blood pressure (even if treated) | Type 2 diabetes |                         |

Any history of tonsillectomy? Yes or No  
 Any history of nasal surgery? Yes or No

**Surgeries or other medical conditions:**

\_\_\_\_\_

\_\_\_\_\_

**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?	How long have you taken it?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

**Do you have any allergies to medication?** \_\_\_\_\_



## Sleep Medicine Questionnaire (continued...)

### Family History

Have any of your relatives had any of the following? If yes, indicate relationship (i.e. father, mother, sibling, children):

Check if positive	Relationship
<input type="checkbox"/> Sleep apnea	_____
<input type="checkbox"/> Loud snoring	_____
<input type="checkbox"/> Restless leg syndrome	_____
<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Insomnia	_____
<input type="checkbox"/> Mental illness	_____
<input type="checkbox"/> Diabetes	_____

Are there any other diseases that run in the family? \_\_\_\_\_

### Sleep Schedule:

Bedtime on **weekdays or work days**: \_\_\_\_\_ Time out of bed for the day: \_\_\_\_\_

Bedtime on **weekends or days off**: \_\_\_\_\_ Time out of bed for the day: \_\_\_\_\_

Number of naps per week: \_\_\_\_\_ At what time? \_\_\_\_\_ How long are the naps? \_\_\_\_\_

Work shift: \_\_\_\_\_ Type of work: \_\_\_\_\_

Any trouble getting to sleep? Yes or No How many times per week? \_\_\_\_\_

Any trouble staying asleep? Yes or No How many times per week? \_\_\_\_\_

Do you use sleep aides (prescription or over-the-counter)? Yes or No

Names of the sleep aides and # of times used per week: \_\_\_\_\_

Caffeinated beverages? Yes or No How many per day? \_\_\_\_\_ How many total ounces? \_\_\_\_\_

Do you smoke cigarettes or use nicotine/tobacco products? Yes or No

Do you drink alcohol? Yes or No # of drinks per day? \_\_\_\_\_ # per week? \_\_\_\_\_

Circle: wine/beer/other liquor

Do you exercise? Yes or No Type of exercise: \_\_\_\_\_ Days per week: \_\_\_\_\_



## Epworth Sleepiness Scale

Do you become sleep in the following situations? Answer with a number 0 – 3 as indicated below:

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

**Situation:**

**Chance of Dozing:**

Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes at a stoplight or in traffic	_____
<b>Total Score:</b>	_____



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.**



**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**

I hereby acknowledge that I received a copy of the Notice of Privacy Practices pertaining to the doctors who participate in the Connect the Docs Network. I further acknowledge that a current version with any revisions that may be made will be posted at [www.ctdmsso.com](http://www.ctdmsso.com). I acknowledge that my health information may be used and disclosed to Connect the Docs Medical Management, Inc. (“CTDMM”), a management services entity, to the extent CTDMM needs the information to schedule appointments with any other health care providers, coordinate my care, remind me of appointments, or to provide other services that pertain to my treatment, payment for services and the health care operations of Physician members of Connect the Docs, A Multi-Specialty Network, Inc.

**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\_**

**Responsible Parties Signature (if other than patient) \_**

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**Thank you for choosing The Neurology Center!**