



# 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 \_\_\_\_\_

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.

Table with 2 columns: Approved Person(s), Relationship to Patient

- Checkboxes for medical information disclosure: routine results, only to me, 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)

Table with 3 columns: Providers Name, Phone Number, City

X Signature Date Relationship to Patient



## Sleep Medicine Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Provider \_\_\_\_\_

Reason for your visit today? \_\_\_\_\_

Do you snore?	Yes / No / Don't know	If yes, answer the following by circling:		
	Circle one			
Snoring is:	Rare            1-2 x/week	3-4 x/week	every night	
Snoring is:	Soft            Moderately loud	Loud enough to be heard outside bedroom		
Snoring is:	Only when lying on your back	Present in any position		
Does snoring disrupt the bed-partner's sleep?	Yes or No			
Has anyone told you that you stop breathing during sleep?	Yes or No			
Any episodes of gasping or choking during sleep?	Yes or No			
Have you gained weight in the past year?	Yes or No	If yes, How many lbs?	_____	
Have you gained weight over the past 5 years?	Yes or No	If yes, How many lbs?	_____	

**Please circle any symptoms that you experience with your sleep:**

Discomfort in legs	Kicking during sleep	Restless sleep
Frequent awakenings	Grinding/Clenching teeth	Frequent (>1) urination at night
Shortness of breath	Excessive perspiration	Racing heartbeat
Morning headaches	Frequent heartburn	Nasal congestion

**Please answer the following questions if you have previously had a sleep study or have been diagnosed with a sleep disorder. Otherwise, skip to the next section:**

Have you ever had a sleep study either at home or in a sleep laboratory facility?            Yes    or    No

If yes, When and Where? \_\_\_\_\_



**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>	_____



## 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. \*\*\***





**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 (HIPAA). 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** \_\_\_\_\_

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

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