

REGISTRATION FORM
Please fill in all required fields

Patient's Last Name _____ First Name _____

Street Address or PO Box _____

City _____ State _____ Zip _____

Patient's home phone # (_____) _____ Patient's cell phone # (_____) _____

Which phone # is your primary #? (for appointment confirmation calls, etc.) (PLEASE CHOOSE ONE) Home Cell

Patient's date of birth _____ Sex: Male Female Marital Status: Single Married Divorced Widowed

Race: (PLEASE CHOOSE ONLY ONE) African American Asian White American Indian Native Hawaiian Declined

Ethnicity: (PLEASE CHOOSE ONLY ONE) Hispanic Not Hispanic Declined

Language _____ SSN _____

Emergency phone # (_____) _____ Emergency contact's name _____

Emergency contact's relationship _____ Patient's e-mail address _____

Referring physician's name/address/phone # _____

Family physician's name/address/phone # _____

Patient's employer _____ Patient's employer's phone # (_____) _____

Spouse's name _____ Spouse's cell # (_____) _____

Spouse's date of birth _____ Spouse's SSN _____

Spouse's employer _____ Spouse's employer's phone # (_____) _____

Primary insurance _____

Policy # _____ Group # _____

Patient's relationship to subscriber: Self Spouse Child Subscriber's name _____

Subscriber's date of birth _____ Subscriber's employer _____

Secondary insurance _____

Policy # _____ Group # _____

Patient's relationship to subscriber: Self Spouse Child Subscriber's name _____

Subscriber's date of birth _____ Subscriber's employer _____

1. Is this a work-related injury? Yes No *****If yes, please notify the receptionist.**

2. Is patient 17 years of age or younger? Yes No If yes:

Responsible party's name _____ Responsible party's SSN _____

Patient's school _____ Grade _____

REGARDING TREATMENT: I hereby authorize the physician (s) at The NeuroMedical Center Clinic in charge of the care of _____ (patient's name) to administer any treatment, therapy or testing that may be deemed necessary or advisable in the diagnosis and treatment of this patient.

REGARDING PRESCRIPTION REFILLS: Telephone prescription refills must be requested Monday – Thursday between the hours of 8:30 a.m. and 5:00 p.m. Telephone prescription refills may be delayed due to the physician's necessity to review your record determining the appropriate medicine to prescribe. Also, please note that it is our belief that narcotic pain relievers are, in general, for short-term use only. These policies are in your best interest and we thank you for understanding.

AUTHORIZATION/RELEASE/ACKNOWLEDGEMENT:

- I authorize The NeuroMedical Center Clinic to accept assignment of benefits.
- I authorize payment of medical benefits to The NeuroMedical Center Clinic.
- I am responsible for co-insurance, co-payments, and/or deductibles at the time of service.
- If my insurance is non-contracted (out of network), the clinic will courtesy file the claim for services rendered.
- If I have no insurance, fees will be due at the time of service.
- A fee of \$20 will be charged for all returned checks.
- If I fail to arrive or fail to cancel my appointment within 24 hours, a No Show Fee will be charged (\$65 per hour for Psychology Testing, \$35 for all other appointments).
- All previous balances owed will be requested at the time of registration.
- Refunds will be issued for any overpayments upon request, if the total account balance is zero.
- In the event any fees for professional medical services are not paid timely, I will be legally responsible for all costs of collections, including 25% attorney's fees, court costs and legal interest.
- I authorize disclosure and/or release of any medical information necessary to process insurance forms, requested by attorneys, physicians, insurance companies, employers, health care providers, or any other entity which may be concerned with payment of charges incurred at The NeuroMedical Center Clinic..
- I authorize The NeuroMedical Center Clinic to obtain medication history via our EMR system from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment. I understand this may be revoked upon written notice, except to the extent that action has already been taken on this authorization.
- I have received a copy of The NeuroMedical Center Clinic's Notice of Privacy Practices.
- I acknowledge and agree that The NeuroMedical Center Clinic and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify The NeuroMedical Center Clinic if I have given up ownership or control of any such telephone number.

I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

Step 1. Check the box below

By Checking this box and typing my name below, I am electrically signing my patient registration form.

Step 2. Type in your name

First Name _____ Middle Initial _____ Last Name _____

I have signed this application as an authorized representative on behalf of the applicant.

If other than patient, relationship to patient: _____

NURSING INTAKE FORM

Patient Name _____ Date of Birth _____ Date _____

Reason for your visit _____

Referring M.D. _____ Primary Care M.D. _____

Height _____ Weight _____ Right handed or Left handed

(For office use only)

BP _____ BMI _____ Growth chart (if applicable) _____

Date of last flu vaccination _____ Date of last pneumonia vaccination _____

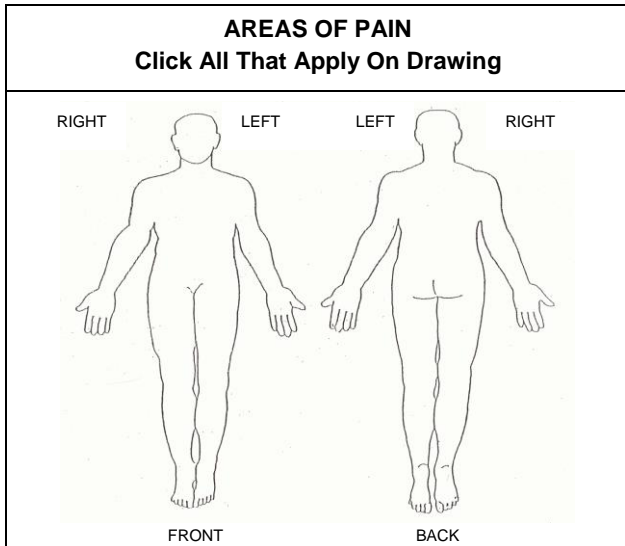
Do you smoke? No Yes (amount per day) _____

Do you use tobacco in any other form? No Yes *If yes, cigars smokeless

How many years have you used tobacco? _____

Do you drink caffeine? No Yes (amount) _____

Do you drink alcohol? No Yes (amount per day) _____



Please select your current level of pain:
(0= No pain and 10= Unbearable pain)

Family Medical History: (Please include for your mother, father, and siblings.)

Social History:

Marital status: _____ Children: _____

Occupation: _____

Level of education: _____

Past Medical History: (Please check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Heart valve | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> TIA |
| <input type="checkbox"/> Type: _____ | <input type="checkbox"/> High cholesterol | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hypothyroidism | |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Kidney failure | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Parkinson's | |

Other _____

Past Surgical History: (Please check all that apply.)

- | | | |
|--|---|---|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Cholecystectomy
(gallbladder) | <input type="checkbox"/> Neck surgery |
| <input type="checkbox"/> Back surgery | <input type="checkbox"/> Gastric bypass | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> CABG (bypass) | <input type="checkbox"/> Knee (scope) | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Carotid surgery | <input type="checkbox"/> Knee replacement | <input type="checkbox"/> TAH (hysterectomy) |
| <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Mitral valve | <input type="checkbox"/> Tubal ligation |

Other _____

Current Medications: (Please include dosage and how often you take the medication.)

Pharmacy Name/Address: _____

Pharmacy Phone Number: _____

Allergies/Reactions: (Please include medication, food and environmental allergies.)

Seafood allergy? No Yes Latex allergy? No Yes

Review of Systems: (Please check symptoms that you are currently experiencing.)

<p>General</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Fatigue/weakness</p> <p><input type="checkbox"/> Malaise</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Sleep Disorder</p> <p>Eyes</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Eye irritation</p> <p><input type="checkbox"/> Drainage from your eyes</p> <p><input type="checkbox"/> Vision loss</p> <p><input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> Sensitivity to light</p> <p>ENT</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Ear drainage</p> <p><input type="checkbox"/> Ringing in your ears</p> <p><input type="checkbox"/> Decreased hearing</p> <p><input type="checkbox"/> Nasal congestion</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Hoarseness</p> <p>CV</p> <p><input type="checkbox"/> Chest pains/palpitations</p> <p><input type="checkbox"/> Passing out</p> <p><input type="checkbox"/> Trouble breathing w/ activity</p> <p><input type="checkbox"/> Trouble breathing unless standing</p> <p><input type="checkbox"/> Waking up at night unable to breathe</p> <p><input type="checkbox"/> Swelling in your feet</p>	<p>Resp</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Trouble breathing at rest</p> <p><input type="checkbox"/> Excessive sputum/phlegm</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Pleurisy</p> <p>GI</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Change in bowel habits</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Blood in your stool</p> <p><input type="checkbox"/> Jaundice/yellowing of your skin</p> <p><input type="checkbox"/> Gas/Bloating</p> <p><input type="checkbox"/> Indigestion/heartburn</p> <p><input type="checkbox"/> Trouble swallowing</p> <p>GU</p> <p><input type="checkbox"/> Loss of control of bladder</p> <p><input type="checkbox"/> Trouble urinating</p> <p><input type="checkbox"/> Urinary frequency</p> <p><input type="checkbox"/> Pelvic pain</p> <p>MS</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Joint swelling</p> <p><input type="checkbox"/> Muscle cramps</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Muscle stiffness</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> Restless legs</p> <p><input type="checkbox"/> Leg pain at night/with activity</p>	<p>Derm</p> <p><input type="checkbox"/> Rash/itching/dryness to skin</p> <p><input type="checkbox"/> Suspicious lesions on skin</p> <p>Neuro</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Vertigo</p> <p><input type="checkbox"/> Episodes of blindness</p> <p><input type="checkbox"/> Frequent falls</p> <p><input type="checkbox"/> Frequent headaches</p> <p><input type="checkbox"/> Difficulty walking</p> <p>Psych</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Suicidal thoughts</p> <p><input type="checkbox"/> Hallucinations</p> <p><input type="checkbox"/> Paranoia/phobia</p> <p><input type="checkbox"/> Confusion</p> <p>Endo</p> <p><input type="checkbox"/> Cold/heat intolerance</p> <p><input type="checkbox"/> Excessive thirst/hunger</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Unusual weight change</p> <p>Heme</p> <p><input type="checkbox"/> Abnormal bruising/bleeding</p> <p><input type="checkbox"/> Enlarged lymph nodes</p> <p>Allergy</p> <p><input type="checkbox"/> Itching or rash to skin</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Recurrent infections</p>
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-or- You are currently not experiencing any symptoms.