The NeuroMedical Center CLINIC
Experts for the Brain, Spine, & Nervous System

REGISTRATION FORM
Please fill in all required fields

10101 Park Rowe Avenue
Baton Rouge, LA 70810
Phone: 225.769.2200
TheNeuroMedicalCenter.com

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____

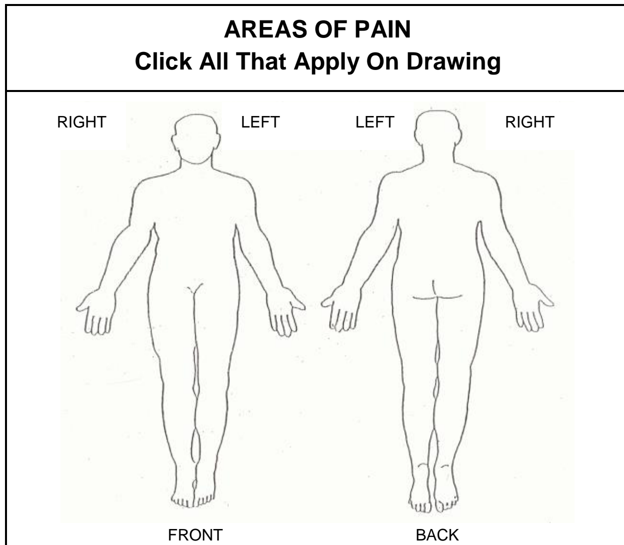
Referring M.D.______________________________ Primary Care M.D.________________________________

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)______________________________

AREAS OF PAIN
Click All That Apply On Drawing



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.)**

- ☐ Anemia
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Cancer
- ☐ Type:_________
- ☐ Cataracts
- ☐ Congestive heart failure
- ☐ Diabetes
- ☐ Dialysis
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart valve
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Kidney failure
- ☐ Migraines
- ☐ Parkinson's
- ☐ Peptic ulcer disease
- ☐ Reflux
- ☐ Seizures
- ☐ Sleep disorder
- ☐ Stroke
- ☐ TIA

Other_________________________________

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

- ☐ Amputation
- ☐ Back surgery
- ☐ Breast surgery
- ☐ CABG (bypass)
- ☐ Carotid surgery
- ☐ Carpal tunnel
- ☐ Cataract
- ☐ C-Section
- ☐ Cholecystectomy (gallbladder)
- ☐ Gastric bypass
- ☐ Hip Replacement
- ☐ Knee (scope)
- ☐ Knee replacement
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Mitral valve
- ☐ Neck surgery
- ☐ Pacemaker
- ☐ Shoulder
- ☐ Sinus
- ☐ TAH (hysterectomy)
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ 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.)

General	Resp	Derm
☐ Fever	☐ Cough	☐ Rash/itching/dryness to skin
☐ Chills	☐ Trouble breathing at rest	☐ Suspicious lesions on skin
☐ Sweats	☐ Excessive sputum/phlegm	**Neuro**
☐ Anorexia	☐ Coughing up blood	☐ Paralysis
☐ Fatigue/weakness	☐ Wheezing	☐ Tingling
☐ Malaise	☐ Pleurisy	☐ Numbness
☐ Weight loss	**GI**	☐ Seizures
☐ Sleep Disorder	☐ Nausea	☐ Tremors
Eyes	☐ Vomiting	☐ Vertigo
☐ Blurred vision	☐ Diarrhea	☐ Episodes of blindness
☐ Double vision	☐ Constipation	☐ Frequent falls
☐ Eye irritation	☐ Change in bowel habits	☐ Frequent headaches
☐ Drainage from your eyes	☐ Abdominal pain	☐ Difficulty walking
☐ Vision loss	☐ Blood in your stool	**Psych**
☐ Eye pain	☐ Jaundice/yellowing of your skin	☐ Depression
☐ Sensitivity to light	☐ Gas/Bloating	☐ Anxiety
ENT	☐ Indigestion/heartburn	☐ Memory loss
☐ Earache	☐ Trouble swallowing	☐ Suicidal thoughts
☐ Ear drainage	**GU**	☐ Hallucinations
☐ Ringing in your ears	☐ Loss of control of bladder	☐ Paranoia/phobia
☐ Decreased hearing	☐ Trouble urinating	☐ Confusion
☐ Nasal congestion	☐ Urinary frequency	**Endo**
☐ Nose bleeds	☐ Pelvic pain	☐ Cold/heat intolerance
☐ Sore throat	**MS**	☐ Excessive thirst/hunger
☐ Hoarseness	☐ Back pain	☐ Frequent urination
CV	☐ Joint pain	☐ Unusual weight change
☐ Chest pains/palpitations	☐ Joint swelling	**Heme**
☐ Passing out	☐ Muscle cramps	☐ Abnormal bruising/bleeding
☐ Trouble breathing w/ activity	☐ Muscle weakness	☐ Enlarged lymph nodes
☐ Trouble breathing unless standing	☐ Muscle stiffness	**Allergy**
☐ Waking up at night unable to breathe	☐ Arthritis	☐ Itching or rash to skin
☐ Swelling in your feet	☐ Sciatica	☐ Hay fever
	☐ Restless legs	☐ Recurrent infections
	☐ Leg pain at night/with activity	

-or-☐ You are currently not experiencing any symptoms.