Clinic of Neurology, Ltd.

Patient Registration Forms

Date:_____

Patient Information:

Last:_____ First:_____ M.I._____
Address:_____City:_____ST:_____Zip:_____
Phone Number: (_____)_____-_____ Email Address:_____
Date of Birth:_____/_____/_____ Sex: Male☐ Female☐ S.S.#:_____
Primary/Ref. Dr. Name:_____ Phone:(_____)_____-_____
Work Status: Full Time☐ Part Time☐ Retired☐ Student☐ Marital Status: S☐ M☐ D☐ W☐
Employer:_____ Phone:(_____)_____-_____
Occupation:_____

Emergency Contact Information (Not Living With You)

Name:_____ Phone:(_____)_____-_____

Payment & Insurance Information (**We need a Copy of your Insurance card**)

Primary Insurance:_____ ID #:_____
Policy Holder Name:_____ Date of Birth:_____/_____/_____
Relationship to Patient (Circle one): Self Spouse Parent Other

Other Insurance or Attorney Name:_____
ID/Claim #:_____ Date of Accident/Injury:_____/_____/_____
Policy Holder Name:_____ Date of Birth:_____/_____/_____
Relationship to Patient (Circle one): Self Spouse Parent Other

Consent to Treatment
The undersigned acknowledges that he/she has requested healthcare services from the Clinic of Neurology, Ltd. (Dr. Neal Pollack). I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment.

Disclosure of Information
All information provided to the Clinic of Neurology, Ltd. is strictly confidential except for the following circumstances: 1. Your insurance company requests information about your treatments in order to process a claim or certify care; 2. The patient authorizes the release of information by signing a release form naming the specific person to receive the information; 3. Certain circumstances where we are required by law to release patient information such as, but not limited to, court subpoena, suspected abuse, etc.

Acknowledgement and Agreement
I have read the above information and thoroughly acknowledge and agree to all of the above information.

_____	_____	_____
Printed Name of Patient Or Representative	Signature	Date

Notice of Privacy Practices (HIPPA) I acknowledge that I have received or was offered a copy of the Clinic of Neurology, Ltd.'s Notice of Privacy Practices.

_____	_____	_____
Printed Name of Patient Or Representative	Signature	Date

Guarantee of Payment
I understand that I am responsible for payment of all fees and services rendered. I have been advised that if my health insurance carrier declares that the services I receive are not considered reasonable and medically necessary, I will be responsible for payment of these services. I authorize payment of benefits from my insurance carrier directly to the Clinic of Neurology, Ltd. **Please note payment is required at the time of service. A $25.00 fee will be charged for returned checks.**

I have read and understand my financial responsibilities outlined in this document.

_____	_____	_____
Printed Name of Patient Or Representative	Signature	Date

NEW PATIENT QUESTIONAIRE

Patient Name:_____ **Date**:_____

What is the reason for your visit today?_____
How long have you had the symptoms?_____days/weeks/months/years.
Does anything make your symptoms better?_____
Does anything make your symptoms worse?_____

MEDICATIONS: Please list all medications that you are currently taking & dosage.

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

ALLERGIES: Please list all medications that you are allergic or intolerant to.

_____

SURGICAL HISTORY: Please lit all surgeries & year performed.

1._____ 4._____
2._____ 5._____
3._____ 6._____

FAMILY HISTORY: Please state whether your parents are living or deceased. If living, list all health conditions. If deceased, list age & cause of death.

Mother:_____
Father:_____

SOCIAL HISTORY:

Are you single, married, widowed or divorced?_____
How many biological children do you have? _____ Stepchildren?:_____
Do you smoke? Yes ☐ No ☐: If yes, how many cigarettes do you smoke per day:_____
Do you drink alcohol? Yes ☐ No ☐: If yes, how much & how often:_____

WORK HISTORY

Are you currently working? Yes☐ No☐ : If yes, what is your occupation?_____
Are you disabled? Yes☐ No☐: If yes, how long have you been disabled?_____
What caused you to become disabled?_____

REVIEW OF SYSTEMS
Please circle any of the following problems that you are now experiencing.

Associated/Constitutional: Loss of appetite
Endocrine: Diabetes, Thyroid, Weight change
Hematologic/Lymphatic: Anemia, Hepatitis
Allergic/Immunologic: Allergies, Cancer
ENT: Decreased hearing, Ringing in ear, Sinus trouble, Difficulty swallowing
Eyes: Double vision, Blurred vision, Failing vision
Lungs/Respiratory: Asthma, Wheezing, Shortness of breath
Heart/Cardiovascular: Chest pain, High blood pressure, Heart murmur, Irregular pulse
ABD/Gastrointestinal: Heart burn, Gout, Nausea, Vomiting, Abdominal pain, Diarrhea, Constipation, Hemorrhoids
GENT/Genitourinary: Overnight urination, Urine infections
BJE/Musculoskeletal: Joint/muscle pain, Arthritis, Back pain, Neck pain
Skin: Rash, Lumps, Itching
Neuro: Seizures, Tremors, Weakness, Numbness, Headaches, Memory loss
Psych: Depression, Moodiness, Difficulty sleeping, Anxiety

PAIN DIAGRAM
Please mark the area/s of injury or discomfort on the chart below.