PATIENT REGISTRATION

PLEASE ANSWER COMPLETELY. ANY INACCURATE OR INCOMPLETE INFORMATION MAY RESULT IN A DENIAL BY YOUR INSURANCE COMPANY AND YOU BEING RESPONSIBLE FOR ALL CHARGES INCURRED.

DATE ______________________ SS# ____________________________________

LAST NAME: ____FIRST NAME: ____

SEX: ___________ DOB: _________________ AGE: _______________________MARITAL STATUS: ________________________

ADDRESS: ____

CITY: ______________________________ STATE: ____________________ ZIP CODE: ___________________

HOME PHONE: __________________________________ WORK/CELL PHONE: ____________________________________

EMPLOYER: ____ OCCUPATION:____

EMAIL ADDRESS: ____

OTHER CONTACT NAME: ____ RELATIONSHIP: ________________________

TELEPHONE #: ____

EMERGENCY CONTACT THAT DOES NOT LIVE WITH YOU:

NAME: ____ **PHONE #:** _____________________________

PRIMARY CARE PHYSICIAN: ____ PHONE #: ____________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE: ____________________________________ ADDRESS: ____

CITY: _______________________________STATE: ___________ZIP CODE: ___________PHONE#:_____________________________

INSURED'S NAME: ___________________________________DOB: _________________SS#: ________________________________

INSURED'S ID #: ____ GROUP #: ____

RELATIONSHIP TO PATIENT: _________________________EMPLOYER: ____

SECONDARY INSURANCE: ____________________________________ ADDRESS: ____

CITY: _______________________________STATE: ___________ZIP CODE: ___________PHONE#:_____________________________

INSURED'S NAME: ___________________________________DOB: _________________SS#: ________________________________

INSURED'S ID #: ____ GROUP #: ____

RELATIONSHIP TO PATIENT: _________________________EMPLOYER: ____

PATIENT HISTORY INTAKE INFORMATION

PATIENT NAME:____ **Date:** ___________ _____________________

ALLERGIES: Please indicate any allergies you have ______No know allergies
I am allergic to: ____

PAST MEDICAL HISTORY – PLEASE INDICATE IF YOU HAVE BEEN DIAGONSED WITH ANY OF THE FOLLOWING:

_______High Blood Pressure ______Stroke ______Aneurysm (Brain)
_______Heart Disease ______Lung Disease _______Cancer
_______Asthma _______Arthritis _______Kidney Disease
_______Blood Vessel Blockage _______ Blood Disorders _______Hepatitis
_______Lupus _______HIV _______Ulcers
_______Depression/Anxiety _______ Diabetes _______ Migraines
_______High Cholesterol _______Alcoholism

Please list any other diagnosis you have had:
____

SURGERIES: (PLEASE LIST ALL SURGIES YOU HAVE HAD AND DATES OF EACH SURGERY)

____

____

SMOKING STATUS: **Please** indicate status below

___Never smoked ___Current Smoker daily ___Former Smoker ___Current Smoker some days

If Former Smoker – How long has it been since you quit smoking? _________Current Smoker – How much daily?
____

SOCIAL HISTORY:

___Never drink Alcohol___ Occasional alcohol Intake ___Moderate Alcohol Intake ___Heavy Alcohol Intake
___Never use drugs ___ Occasional use of drugs ___Moderate drug use ___Heavy drug usage

FAMILY HISTORY – Please indicate family member – mother-mo., father-fa., sister-sis. or brother-br.
___High Blood Pressure – Family member________ ___Stroke – Family Member _________

___Cancer – Family Member ______Type of Cancer __________ ___ Lung Disease – Family Member _________

___Heart – Family Member ____________ ___Mental Retardation: Family Member - ______________

___Depression/Anxiety – Family Member __________ ___Mental Conditions – Family Member_________

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer. You may obtain a copy of this by requesting one.

Patient's Last Name ______________________________ **First** ______________________________ **MI** ________

Sex ☐ Male ☐ Female **Date of Birth:** ______________________ **HT**__________ **WEIGHT**_________

Name of Primary Care Physician: ____

Pharmacy Preference (NAME & PHONE NUMBER): ____________________________________

REASON FOR TODAY'S VISIT: ____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	**Dosage**	**How Often Taken**

ARE YOU ALLERGIC TO ANY MEDICATION? _____ **Yes** _____ **No.** If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS.

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____Yes ____No
If yes, please list type of problems:

____
____
____

Have you ever been hospitalized for non-surgical reasons? ___Yes ___No

If yes, list reasons for hospitalizations

____
____

CURRENT OR MOST RECENT OCCUPATION: ______________________________________

Tri-State Neurology Practice Guidelines

1. Scheduled appointments:

We understand that delays can happen however we must try to keep other patients and the doctor on time. If you are more than 15 minutes past your appointment time without speaking to someone from our office, we have the right to reschedule your appointment.

2. Cancellation/No show policy:

We understand that there are times when you must miss or cancel an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. More than 3 no showed appointments (or giving less than 24-hour notice for canceling) in a 12-month period could result in no longer being able to schedule with our provider for future appointments.

By signing below, I understand that these policies apply to me and my care with Tri-State Neurology. If I have questions about the policy. I will ask a staff member before signing.

______________________________ ____________________________________

Print Patient Name | Signature Patient/Guardian

______________________________ ____________________________________

Date | Relationship/Guardian