PATIENT REGISTRATION FORM
Carolina Neurology Center, PLLC

PERSONAL INFORMATION:

Name: _____ **Referring Physician:** _____
Date of Birth: _____ **Emergency Contact:** _____
Social Security #: _____ **Emergency Phone:** _____
Mailing Address: _____ **Emergency Relationship:** _____
City: _____ **Patient's Employer:** _____
State: _____ **Zip Code:** _____ **Employer's Address:** _____
Home Phone: _____ **City:** _____
Cell Phone: _____ **State:** _____ **Zip Code:** _____
Email:_____ **Occupation:** _____

RESPONSIBLE PARTY: **Person Responsible for payment (if different than above)**

Name: _____ **Home Phone:** _____
Mailing Address: _____ **Date of Birth:** _____
City: _____ **Social Security #:** _____
State: _____ **Zip Code:** _____ **Employer of Responsible Party:** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby authorize CAROLINA NEUROLOGY CENTER to release any Information necessary for my course of treatment to:
"X" indicates information that may be shared with those specific

□ **ANY/ALL INFORMATION MAY BE SHARED** **Initial** _____

□ My spouse _____ **Initial** _____ □ Appointment time/date **Initial** _____
□ My significant other _____ **Initial** _____ □ Medication(s) **Initial** _____
□ Other _____ **Initial** _____ □ Radiology/Laboratory results **Initial** _____
□ Leave a message on my answering machine **Initial** _____ □ Procedure/Surgery Information **Initial** _____

MEDICAL CONSENT: **I consent to the examination treatment and procedures which may be performed during the office visit including emergency treatment considered necessary by the physician. If any invasive procedure is necessary, a specific consent form will be discussed with me at that time.**

FINANCIAL POLICY: **Payment of deductible or co-payment is expected at the time of service. Cash, check, Master Card and VISA are acceptable methods of payment. Insurance claims for each service date will be submitted to your insurance company twice after which time responsibility for payment will be yours.**

PAYMENT AUTHORIZATION AND ASSIGNMENT: **I hereby authorize CAROLINA NEUROLOGY CENTER to release any information required the course of my examination or treatment. I authorize payment directly to the CAROLINA NEUROLOGY CENTER for the medical/surgical benefits. If, otherwise payable to me for services, I understand that I am financially responsible for the charges not covered by my insurance.**

PRINT NAME:_____

SIGNATURE _____ **DATE** _____

Health Questionnaire

Full Name_____ **DOB**___/___/_____ **Height**_____ **Weight**_____
Last **First** **Middle**

Unless you instruct us otherwise, a report will be sent to your referring physician and to your primary care physician.

Name of Referring Physician_____

Name of Primary Care Physician_____

What is the reason for today's visit

_____

_____

Result of Accident: YES___NO___ If yes, give date(s) and describe

_____

Is this examination to determine disability status for the government or Insurance Company? ____ Yes ____No
Have you had an injury for which there is now a lawsuit pending? ____ Yes ____ No

Are you employed now? _____ Last date worked ____/____/____ Occupation _____
Duties _____ **Heavy Lifting ____ Yes ____ No**

PAST MEDICAL HISTORY

Have you ever had any of the following (circle):

Asthma	**Yes No**	**Kidney stones**	**Yes No**	**Migraine/Headaches**	**Yes No**
Cancer _____	**Yes No**	**Stroke**	**Yes No**	**Neck Injury**	**Yes No**
Diabetes	**Yes No**	**Fibromyalgia**	**Yes No**	**Thyroid trouble**	**Yes No**
Arthritis	**Yes No**	**Phlebitis**	**Yes No**	**Parkinson's Disease**	**Yes No**
Heart murmur	**Yes No**	**Blood Clots**	**Yes No**	**Ulcers**	**Yes No**
Heart attack (Year____)	**Yes No**	**Sleep Disorder**	**Yes No**	**Epilepsy**	**Yes No**
Depression	**Yes No**	**Hypertension**	**Yes No**	**Multiple Sclerosis**	**Yes No**

CURRENT MEDICAL PROBLEMS NOT LISTED ABOVE:

_____

_____

_____

Surgical (Please list all surgeries with their date even if unrelated to today's visit):

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4)_____ **8)** _____

Additional

Surgeries:_____

FAMILY HISTORY (List ages and diseases)

	Living	Age	Any known medical condition or cause of death
Mother	____	___	_____
Father	____	___	_____
Brother's	____	___	_____
Sister's	____	___	_____
Children	____	___	_____
	____	___	_____
	____	___	_____
Other Relative's	____	___	_____
	____	___	_____

SOCIAL:

Tobacco _____ Yes _____ No At what age did you start smoking?_____

Type of Tobacco_____ Amount/Per Day _____# of Years ____ If stopped, when _____

Alcohol _____ Yes _____ No Amount, including beer, wine, and liquor _____

Marital Status (Circle) Married Single Widowed Divorced Separated

EDUCATION (circle):

Years of school: 7 8 9 10 11 12 13 14 15 16 17 18 19 20

REVIEW OF SYSTEMS:

Do you have any of the following: PLEASE CHECK EITHER YES OR NO

GENERAL		
	Recent weight gain (amount) _____	_____ Yes _____ No
	Recent weight loss (amount) _____	_____ Yes _____ No
	Fever	_____ Yes _____ No
ENDOCRINE		
	Thyroid Disease	_____ Yes _____ No
	Diabetes	_____ Yes _____ No
	Fatigue	_____ Yes _____ No
NEUROLOGICAL		
	New, frequent or severe headaches	_____ Yes _____ No
	Dizziness	_____ Yes _____ No
	Blackouts	_____ Yes _____ No
	Confusion	_____ Yes _____ No
	Memory problems	_____ Yes _____ No
	Change in speech or voice	_____ Yes _____ No
	Numbness/tingling	_____ Yes _____ No
	Loss of balance/difficulty walking	_____ Yes _____ No
	Shaking, tremor or jerking	_____ Yes _____ No
	Weakness	_____ Yes _____ No
	Loss of consciousness, fainting or convulsions	_____ Yes _____ No
HEAD/EYES/EARS/NOSE/THROAT		
	Glaucoma	_____ Yes _____ No
	Eye pain	_____ Yes _____ No
	Blurred vision/double vision	_____ Yes _____ No
	Do you use a hearing aid?	_____ Yes _____ No
	Trouble chewing or swallowing	_____ Yes _____ No

CARDIOVASCULAR/RESPIRATORY

Daily cough or cough with bloody phlegm	_____ Yes	_____ No
Short of breath after walking up two flights of stairs or hurrying	_____ Yes	_____ No
Discomfort or pain in chest	_____ Yes	_____ No
Swelling of the ankles every day	_____ Yes	_____ No
Any leg or foot discomfort at night	_____ Yes	_____ No
High blood pressure (how many years ____)	_____ Yes	_____ No

GASTROINTESTINAL

Abdominal Pain	_____ Yes	_____ No
Frequent heartburn or indigestion	_____ Yes	_____ No
Change in bowel habits	_____ Yes	_____ No
Black or bloody bowel movements	_____ Yes	_____ No

GENITOURINARY

Difficulty urinating	_____ Yes	_____ No
Do you lose control of urine at times?	_____ Yes	_____ No
Awaken at night more than once to urinate	_____ Yes	_____ No
Sexual problems or change in sexual drive	_____ Yes	_____ No

MENSTRUAL/PREGNANCY/MENOPAUSE

History of menstrual irregularities	_____ Yes	_____ No
History of miscarriages	_____ Yes	_____ No
History of menopause	_____ Yes	_____ No

ESTROGENS

Hormone replacement therapy	_____ Yes	_____ No
Birth Control	_____ Yes	_____ No

BREAST DISEASE

History of breast disease	_____ Yes	_____ No
History of breast cancer	_____ Yes	_____ No

SKIN

Any changes in skin, moles, rash?	_____ Yes	_____ No

MUSCULOSKELETAL

Persistent painful, stiff or swollen joints	_____ Yes	_____ No
Back pain or discomfort	_____ Yes	_____ No

PSYCHIATRIC

Stress or frequent conflicts at home	_____ Yes	_____ No
Do you feel anxious or depressed much of the time?	_____ Yes	_____ No
Have you seriously considered suicide?	_____ Yes	_____ No
Difficulty in sleeping	_____ Yes	_____ No
History of hospitalization for an emotional problem	_____ Yes	_____ No

_____Date ___/__/____

Patient Signature

Carolina Neurology Center, PLLC

MEDICATION LIST

Patient's Name _____ Date of Birth _____/_____/_____

Pharmacy Name & Location _____

Please List Allergies:

_____

_____

Prescription Name	*Milligrams (Dosage)*	*How do you take it?*	*Approx. Start Date*	*Prescribing Physician*

If you need more room please use the lines below:

_____

_____

_____

Carolina Neurology Center, PLLC

Financial Guideline Agreement

CAROLINA NEUROLOGY CENTER participates with most insurance plans offered in Western North Carolina. Each plan has different benefits for you, the patient, as well as different financial obligations. We will work with you and your insurance plan to determine what part of your fees for medical care are covered by insurance and which parts are payable by you.

In order to keep your address and insurance information accurate, we will need to keep a copy of your current insurance card on file. We will ask you to verify this information if it is more than 30 days old (does not apply to Medicare).

ALL MEDICARE PATIENTS WITHOUT A SECONDARY ARE REQUIRED BY LAW TO PAY THEIR 20% COPAY AT THE TIME OF SERVICE.

Fees for medical care that are not covered by your insurance are due at the time of service. These fees include co-payments for managed care plans, annual deductibles and co-insurance as determined by your insurance company. Additionally, you may be responsible for fees that your insurance does not cover.

I understand the above financial policy and that I will be responsible for paying the self-pay balance at each visit. If I am unable to pay in full at the time of service, prior arrangements will be made with the office.

_____

Patient Name (printed)

_____ _____

Signature (Parent or Responsible Party) **Date**

Form: Payment Guidelines Rev. 7/25/2014

Carolina Neurology Center, PLLC

Missed Appointment Policy

Effective May 20, 2008, a fee of $50.00 will be charged for all missed appointments (office visits-new and follow-up) and a fee of $100.00 for all missed procedure appointments (EEG, EMG, Sleep Studies) without a prior 24 hour notice.

I hereby certify that I have been informed of the office policies of

CAROLINA NEUROLOGY CENTER, LLC regarding missed appointments.

_____	_____	_____
Patient's Name (Print)	**Patient Signature**	**Date**

_____	_____	_____
Witness Name (Print)	**Witness Signature**	**Date**

Form: Missed Appointment Policy Rev. 07/25/2014

Carolina Neurology Center, PLLC
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Recording/ Video Agreement

In order to protect confidential patient information and the rights and privacy of staff, patients and visitors, use of recording devices such as camera (including cell phone cameras), video recorders, audio recorders or any other type of equipment used to capture or record images and/or sound is prohibited past the waiting area.

Thank you for your cooperation.

Patient name: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____