

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 _____
- | | |
|--|--|
| <input type="checkbox"/> My spouse _____ Initial _____ | <input type="checkbox"/> Appointment time/date _____ Initial _____ |
| <input type="checkbox"/> My significant other _____ Initial _____ | <input type="checkbox"/> Medication(s) _____ Initial _____ |
| <input type="checkbox"/> Other _____ Initial _____ | <input type="checkbox"/> Radiology/Laboratory results _____ Initial _____ |
| <input type="checkbox"/> Leave a message on my answering machine _____ Initial _____ | <input type="checkbox"/> 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)

	<u>Living</u>	<u>Age</u>	<u>Any known medical condition or cause of death</u>
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:

<i>Prescription Name</i>	<i>Milligrams (Dosage)</i>	<i>How do you take it?</i>	<i>Approx. Start Date</i>	<i>Prescribing Physician</i>

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

Carolina Neurology Center, PLLC

Missed Appointment Policy

Effective May 20, 2008, a fee of \$25.00 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