Neurology Associates of the East Valley, PLC

2201 W. Fairview St. Suite 1 Chandler, AZ 85224

****Please complete entire form in black ink****

Name: _____ Date of Birth: _____
Last First MI

SS#:_____

Address: _____Gender: M or F Age: _____
Street

_____ Marital Status: S M D W
City State Zip

Telephone: Home ( ) _____ Cell ( ) _____ Work ( ) _____

******Please indicate preferred primary phone number*** ☐ Home ☐ Cell ☐ Work

Employer: _____ Occupation: _____
Name

_____
Street City State Zip

May we contact you via email? YES NO Please provide Email:_____

Primary Care Doctor: _____Primary Care Doctor's Phone #: ( ) _____

Referring Doctor: _____Referring Doctor's Phone #: ( ) _____

Race (circle one): African American Caucasian Hispanic Asian Native American

Primary Language (circle one): English Spanish Other: _____

Who referred you to our office? ☐ Family Physician_____ ☐ Other Physician_____

☐ Friend/Patient:_____ ☐ Other:(define)_____

Emergency Contact Person:

Name: _____ Phone: _____

Relationship to Patient: _____

DO WE HAVE YOUR PERMISSION TO DISCUSS YOUR CASE WITH CERTAIN SPECIFIED RELATIVES AND/OR FRIENDS OF YOUR CHOOSING?

Spouse? YES NO Name: _____

Others? Name/Relationship: _____

Do we have you permission to leave messages on your answering machine at home or voicemail at work? YES NO

Primary Insurance: ***MUST BE COMPLETED BY PATIENT FOR INSURANCE TO BE BILLED FOR SERVICES***

Insurance Plan: _____ Policy Holder: _____

ID #: _____ Group #:_____

Claims
Address:_____
Street City State Zip

SS#: _____ D.O.B:_____

Relationship to Policy Holder: _____

Employer of Policy Holder: _____ Phone:_____

Address:_____
Street City State Zip

Secondary Insurance:

Insurance Plan: _____ Policy Holder: _____

ID #: _____ Group #:_____

Claims
Address:_____
Street City State Zip

SS#: _____ D.O.B:_____

Relationship to Policy Holder: _____

Employer of Policy Holder: _____ Phone:_____

Address:_____
Street City State Zip

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. In the event I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office may release record of my treatment to my insurance company or other third parties responsible for payment of my medical charges.

Patient Signature: _____ Date: _____

Preferred Pharmacy:

Pharmacy Name**:** _____ Phone Number**:** _____

Address:_____
Street City State Zip

Major Crossroads: _____

Medication History Consent:

A medication history is a list of medicines that Neurology Associates and other doctors have recently prescribed for a patient. It is collected from a variety of sources, including, a patient's pharmacy, health plans, other healthcare providers, and the Arizona State Pharmacy Board.

I give my consent for Neurology Associates of the East Valley, PLC to retrieve and review my medication history. I understand that this will become part of my medical record.

Patient Signature: _____ Date: _____

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Financial Policy

Thank you for choosing Neurology Associates of the East Valley for your neurological care. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our staff will be glad to discuss these policies with you.

******PLEASE INITIAL ALL OF THE FOLLOWING:***

1._____ I understand that if I do not have my insurance card, referral, co-payment, deductible, and/or coinsurance that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2._____I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges, which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. My insurance company determines benefit payments. I understand I will be responsible for the portion not covered by my insurance. I understand I am responsible for knowing my financial responsibility for all test and procedures.

3._____I understand that if I am unable to make a scheduled appointment I need to contact the office at least 24 hours prior to my scheduled appointment. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

4._____ ****I understand that missed appointments will NOT be rescheduled until the $50 Fee is paid***

5._____ I understand there is a $25 charge for a Non-Sufficient Funds (NSF) check.

6._____ I understand there is a $150.00 charge for all forms deemed appropriate, filled out by the Physician (e.g. Disability, FMLA, etc.) and I understand that I may require an appointment with the Doctor to fill out these forms, at the provider's discretion.

7._____ I understand if my account is not paid in full within 30 days, a $50 collection-processing fee will be added to the outstanding balance and will be turned over to a collections agency for further processing. **All services will be suspended after 15 days of non-payment for patient accounts with balances.**

8. _____ ***I have read and I understand the above Financial Policy and I agree to abide by its terms.***

Signature of patient (or parent / guardian): _____

Print Name: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Neurology Associates of the East Valley, PLC which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

_____ _____
Signature of the Patient or the Patient's Legal Representative Date

_____
Print Name

FOR OFFICIAL USE ONLY

I, _____, made a good faith effort to obtain written acknowledgement of _____'s receipt of the Notice of Privacy Practices of Neurology Associates of the East Valley, PLC. However, I could not obtain written acknowledgement because:

☐ Individual refused to sign this acknowledgement

☐ Communications barrier prohibited obtaining written acknowledgement

☐ An emergency situation prevented obtaining written acknowledgement

☐ Other (please specify): _____
_____
_____

Name of Patient: _____ Date: _____

MEDICATIONS:

List all current prescription, non-prescription medications, vitamins, and herbal products. Please INCLUDE even occasional use of aspirin or anti-inflammatory medication for arthritis.

Name of Medication	Strength	Frequency Taken

PATIENT'S MEDICAL HISTORY (active or inactive) Check those that are applicable

-GI-
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Reflux, GERD

-CANCER-
- ☐ Breast
- ☐ Skin
- ☐ Prostate
- ☐ Colon
- ☐ Other: _____

-Heart/Lung-
- ☐ Angina
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Mitral Valve Prolapse
- ☐ Heart Valve Disease
- ☐ Atrial Fibrillation
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Asthma
- ☐ COPD; Emphysema
- ☐ Sleep Apnea

-Metabolic/Misc.
- ☐ Kidney Stones
- ☐ Chronic Renal Failure
- ☐ Headaches
- ☐ Diabetes Mellitus
- ☐ Seizures
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis/DJD
- ☐ Osteoporosis
- ☐ Glaucoma
- ☐ Depression
- ☐ Bipolar Disorder

Other medical problems not listed above:

_____
_____
_____
_____

ALLERGIES: ☐ NONE

INCLUDE allergies to medications and other medical products (examples: tape, latex, and iodine).

Name of Medicine or Product: _____

Description of Reaction: _____

SURGICAL HISTORY / HOSPITIALIZATION ☐ None

Type of Surgery and Reason	Year

FAMILY HEALTH HISTORY

	Age (if living)	HEALTH PROBLEMS		AGE	HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

HEALTH HABITS AND PERSONAL SAFETY

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind? _____

How many drinks per week? _____

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes – pks./day _____ ☐ Chew - #/day_____ ☐ Pipe - #/day_____ ☐ Cigars - #/day_____

☐ # of years _____ ☐ or year quit _____

Do you currently use recreational or street drugs? ☐ Yes ☐ No

Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Do you live in an assisted living facility? ☐ Yes ☐ No If yes, what is the name? _____

REVIEW OF SYMPTOMS –*PLEASE CHECK ANY SYMPTOMS YOU HAVE*:

Constitutional Symptoms
□ tendency to feel hot or cold
□ loss of appetite
□ excessive appetite
□ excessive thirst
□ fatigue
□ difficulty sleeping
□ lack of exercise
□ excessive sweating
□ night sweats

Eyes
□ glaucoma
□ blurred vision
□ double vision
□ eye pain or itching
□ watery eyes
□ cataracts

_____

Ear, Nose Throat
□ loss of hearing
□ earache
□ ringing in ears
□ dizziness
□ dental problems
□ sore tongue
□ taste changes
□ swelling of gums
□ nasal congestion
□ sore throat
□ enlarged tonsils
□ hoarse voice

_____

Pulmonary
□ chronic cough
□ cough productive of phlegm
□ coughs up blood
□ chronic bronchitis
□ sleep apnea

_____

Cardiovascular
□ palpitations
□ angina
□ swelling of feet or ankles
□ shortness of breath with exertion
□ two or more pillows at night to breath

Gastrointestinal
□ heart burn
□ difficulty swallowing
□ bloating
□ belching
□ nausea
□ frequent vomiting
□ vomiting blood
□ abdominal pain
□ constipation
□ diarrhea
□ black stools
□ pain in rectum
□ rectal bleeding
□ incontinence of stool

_____

Urogenital
□ nighttime frequency
□ bloody urine
□ urgency
□ difficulty starting to urinate
□ burning on urination
□ urinary incontinence

_____

Musculoskeletal
□ joint pain from arthritis
□ muscle aches
□ back pain
□ joint swelling

_____

Skin
□ chronic skin condition (ex. Psoriasis)
□ recent rash
□ excessive itching
□ acne

_____

Neurological
□ dizziness
□ lightheadedness
□ vertigo
□ numbness
□ tremor
□ seizures
□ traumatic brain injury
□ headache/migraine

Psychiatric
□ depressed
□ difficulty making decisions
□ lack of concentration
□ memory loss
□ cries often
□ worries excessively
□ panic attacks
□ desires psychiatric help
□ alcohol/substance abuse & dependence
□ anxiety
□ bereavement
□ bipolar disorder
□ caregiver stress
□ obsessive-compulsive behavior
□ postpartum depression
□ post-traumatic stress
□ psychosis
□ sadness
□ stress
□ suicidal thoughts or attempts
□ tension

_____

Hematologic
Lymphatic Systems
□ diagnosis of anemia
□ bleeds easily
□ bruises easily
□ swelling of lymph nodes in groin, armpits, neck
□ iron deficiency

Primary Care Physician:

_____

Pharmacy name and crossroads:

_____

□ NO NEW SYMPTIONS

Do you have a pacemaker?
□ YES
□ NO

Name: _____ Date: _____
(PRINT NAME CLEARLY)