MEDICAL ARTS NEUROLOGY CC2
(SPECIAL FORM)

DATE: _____

NEUROLOGIST YOU ARE SEEING: _____

PATIENT'S NAME: _____ DATE OF BIRTH _____

AGE: _____

EMAIL ADDRESS: _____

PRIMARY CARE DOCTOR'S NAME: _____

REFERRING DOCTOR: _____

WHAT IS YOUR CHIEF NEUROLOGICAL COMPLAINT AND REASON TO SEE THE DOCTOR: _____

_____

_____

CURRENT MEDICATIONS NAME AND DOSAGE:

_____

_____

_____

_____

ALLERGIES TO MEDICATIONS: _____

_____

PAST MEDICAL HISTORY:

DIABETES	___	CANCER	___
HYPERTENSION	___	NEUROPATHY	___
HEART DISEASE	___	STROKE	___
MIGRAINES	___	HEADACHES	___
EPILEPSY	___	VERTIGO	___
MENTAL ILLNESS	___	SLEEP DISORDER	___
HIGH CHOLESTEROL	___		

OTHER: _____

IF FEMALE: ARE YOU CURRENTLY PREGNANT? _____

SURGICAL HISTORY:

HOSPITALIZATIONS:

WHAT DISEASES ARE COMMON IN YOUR FAMILY: (FAMILY HISTORY)

	MOTHER	FATHER	SIBLINGS
DIABETES			
ALZHEIMERS			
MIGRAINES			
EPILEPSY			
MUSCULAR DYSTROPHY			
DEMENTIA			
ANEURYSM			
STROKE			
NEUROPATHY			
PARKINSON'S DISEASE			
HYPERTENSION			
CARDIAC DISEASE			
MENTAL DISEASE			
HIGH CHOLESTEROL			
CANCER			
HEADACHES			
VERTIGO			
SLEEP DISORDER			
OTHER:_____			

SOCIAL HISTORY:

	YES	NO
DO YOU SMOKE?	_____	_____
If yes, how many cigarettes per day do you smoke? _____		
DID YOU SMOKE BEFORE?	_____	_____
DO YOU DRINK ALCOHOL?	_____	_____
ARE YOU A FORMER DRINKER?	_____	_____
If yes, how many drinks do you drink per day? _____		
ARE YOU OVER THE AGE OF 65?	_____	_____
If you are over 65 have you experienced any falls?	_____	_____
If you answered yes, Please give # of falls within the last year: _____		
Were you injured in any of the stated falls within the last year:	_____	_____
DO YOU HAVE FEELINGS OF DEPRESSION:	_____	_____
DO YOU USE DRUGS? *If yes, please list drug(s): _____	_____	_____

WORK STATUS:

PROFESSION _____

RETIRED_____ (PREVIOUS OCCUPATION): _____

MARITAL STATUS:

MARRIED_____ SINGLE_____ WIDOW_____ DIVORCED_____

HOW MANY CHILDREN YOU HAVE? _____

WEIGHT _____ HEIGHT _____

RIGHT HANDED _____ LEFT HANDED_____

****For Employee Use ONLY****

WEB ENABLED: YES_____ NO____ IF NO,WHY ?_____

REFERRING PHYSCIAN ENTERED: YES_____ NO_____ IF NO, WHY?_____

Revised 10/22/18.

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

Name/*Nombre*: _____ Date/*Fecha*: _____

Review of System: Please check off any symptoms below./*Por favor de elegir síntomas que usted tenga debajo.*

Constitutional:	Weight Loss/ *Perdida de Peso*	Weight Gain/ *Aumento de Peso*	Fatigue/ *Fatiga*	Headache/ *Dolor de Cabeza*	Fever/ *Fiebre*	None/ *No Síntoma*
Eyes/*Ojos*:	Visual Loss/ *Perdida de Visión*	Double Vision/ *Visión doble*	Eye pain/ *Dolor en los ojos*	Droopy Lids/ *Parpados caídos*	Blurry Vision/ *Visión borrosa*	None/ *No Síntoma*
ENT:Mouth/*Oído, Nariz y Garganta:*	Hearing Loss/ *Perdida en la audicion*	Ringing in Ears/*Ruido en los oídos*	Loss of Smell/*Perdida del olfato*	Can't Swallow/*No puede tragar*	Fainting/ *Mareos*	None/ *No Síntoma*
Cardio Vascular/*Cardio-Vascular:*	Chest Pain/ *Dolor en el pecho*	High Blood Pressure/ *Presión alta*	Palpitations/ *Palpitaciones*	Leg Swelling/*Piernas hinchadas*	Fainting/ *Desmayos*	None/ *No Síntoma*
Respiratory/ *Respiratorio:*	Cough/*Tos*	Bloody Sputum/ *Expectoración con sangre*	Short of Breath/*Falta de aire*	Phlegm/ *Flema*	Night Sweats/ *Escalofríos*	None/ *No Síntoma*
G.I: *Gastroenterología:*	Nausea	Vomiting/ *Vómitos*	Constipated/ *Constipacion*	Diarrhea/*Diarrea*	Black bowel movements/ *Heces negras*	None/ *No Síntoma*
Urinary GU/ *Urinaria :*	Painful Urination/ *Dolor al orinar*	Sexual Problems/ *Problemas sexuales*	Can't empty bladder/*Dificultad al orinar*	Frequent Urination/ *Orinando Frecuenté*	Bloody Urine/ *Orinando con sangre*	None/ *No Síntoma*
Endocrine/ *Endocrino:*	Heat Intolerance/ *Intolerancia al calor*	Cold Intolerence/ *Intolerancia al frío*	Excess Urination/ *Orinar en exceso*	Excess Thirst/ *Sed excesiva*	Always Hungry/ *Siempre con hambre*	None/ *No Síntoma*
Musculoskelatal/ *Músculo-esquelético*	Joint Pain/*Dolor artritico*	Muscle Pain/*Dolor en los músculos*	Weakness/ *Debilidad*	Back Pain/ *Dolor en la espalda*	Neck Pain/ *Dolor en el cuello*	None/ *No Síntoma*
Skin;Breast (Integumentary)/ *Piel;senos:*	Rash/ *Erupciones en la piel*	Itching/ *Picazón comezon*	Change of color/*Cambio de color en la piel*	Milk from Breasts/*Leche de los senos*	Breast Lump/*Masas en los senos*	None/ *No Síntoma*
Neurologic/ *Neurología:*	Numb and Tingling/ *Adormecimiento u hormigueo*	Falling or Imbalance/ *Caídas o sin balance*	Memory Loss/*Perdida de Memoria*	Speech Problems/*Problemas al hablar*	Tremors/ *Temblores*	None/ *No Síntoma*
Psychiatric/ *Psiquiátrico:*	Confusion/ *Confusión*	Hallucinations/ *Alucinaciones*	Feelings of Persecution/ *Sentido de persecución*	Depression/ *Depresión*	Nervous/ *Nerviosismo*	None/ *No Síntoma*
Hemlymph/ *Hematológico:*	Swollen Glands/ *Glándula Inflamadas*	Pallor/ *Palidez*	Bleeding/ *Sangramiento*	Bruising easily/ *Moretones*		None/ *No Síntoma*
Allergic, Immune, Sleep/*Alergias y sueno*	Frequent Infections/ Infecciones frecuente	Food Allergies/ Alergias a las comida	Insomnia/ Insomnio	Sleeping too much/Dormir mucho	Snoring/ Ronquido	None/ *No Síntoma*

Please elaborate any positive symptoms above or any other symptoms/*Por favor elaborar cualquier síntoma escogido arriba u otros síntomas nuevos.* _____

What is you chief medical complaint or medical condition?/*Describa su mayor problema?*

Family Medical/Neurological problems? *Problemas medicos/neurológicos en su familia?*

Previous Surgeries and past medical conditions/*Cirugías o condiciones medicas previas:*

Allergies to any Medications?/ *¿Allergico a algunos medicamentos?* _____

List all of the medications you currently take, including dosages./ *Escriba todos los medicamentos que usted toma en este momento incluyendo la dosis.* _____

Are you working?/*¿Usted estaitrabajando?* _____ Height/*Estatura:*___ Weight/*Peso:*___

Type of Job?/*¿Tipo de trabajo?*_____

Smoking? ___ Yes ___ No, Pack per day? ___/*¿Fuma?* ___ *Si* ___ *No, ¿Paquetes por día?* ___

If you previously smoked when did you quit? _____/*¿Si fumaste antes, hace cuanto tiempo dejo de fumar?*_____

If smoked for how long? _____/*¿Si fumo hace cuanto tiempo?* _____

How many packs per week? _____/*¿Cuantos paquetes por día?*_____

Alcohol Use? Yes No How many drinks per week? */¿Usá alcohol? Si No, ¿Cuántos tragos por semana?*

/ / 2015

_____, _____

Age: ____

HPI:

PSH:

PMH:

Meds:

O: BP / P R

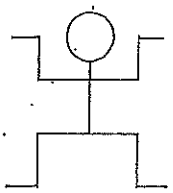
CUS:

Fundus/CN:

Motor: Sensory:

Tone: Coord:

Gait:



SH:

FH:

IMP:

PLAN:

ALLERGIC TO:

MEDICAL ARTS NEUROLOGY

Patient Registration Form

Appt Date: _____ Doctor: _____

Patients Name (Last Name, First Name): _____

Date of Birth: ___/___/___

Home Address: _____ Apt: _____

Zip Code: _____ City: _____ State: ____

Best phone #: ( ) ____-_____ Alternative phone #: ( ) ____-_____

E-mail Address: _____

Gender: ____ Race: _____ Ethnicity: _____

Marital Status: Single ___ Married ___ Legally Separated ____ Divorced ____ Widowed ____

Partner ___

Emergency Contact: _____

Their #: ( ) ____-_____

Your Primary care physician? _____ Phone: _____

Referring physician? _____ Phone: _____

Primary Insurance: _____

Secondary Insurance: _____

Local Pharmacy: _____

Mail away pharmacy/ specialty pharmacy: _____

Patient or Legal Guardian Signature: _____ Date: _____

Medical Arts Neurology
Patient Financial Information Form

Is Your Medical Condition Related To:

Work: YES___ NO____

Auto Accident: YES___ NO___

WORKERS COMPENSATION

Insurance Company: _____

Date of Accident:_____ Claim Number: _____

Employer at the time of the accident: _____

AUTO INSURANCE

Insurance Company _____

Claims Address _____

City: _____ State: _____ Zip: _____

Date of Accident: _____ Claim Number: _____

Signature of Responsible Party: _____ **Date:** _____

MEDICAL ARTS NEUROLOGY
Patient authorization and financial responsibility form

Consent to Treatment

I hereby voluntarily consent to the rendering of medical treatment by the physicians, neuropsychologists, and staff of MEDICAL ARTS NEUROLOGY; this may include examination, diagnostic and / or surgical procedures, administration of injections, and/ or any other such medical treatment deemed necessary for diagnosis and treatment of the patient's medical condition.

Authorization of Release Medical Information

I hereby authorize the physicians, neuropsychologists, and staff of MEDICAL ARTS NEUROLOGY, to release any medical information acquired in the course of my examination and treatment necessary for the processing of this claim and / or for purpose of any insurance payments further authorize the release of said information to my primary care physician, referring physician and /or attorney if applicable. I authorize the release of de-identified information for research and reporting purposes.

Assignment of Insurance Benefits

I hereby authorize my insurance company to make payments on my behalf, of any and all Individual, Group, Workers Compensation, Liability, or PIP Benefits, directly to the provider, the physicians and medical staff of MEDICAL ARTS NEUROLOGY for medical services rendered to me.

Medicare/Medicaid Assignment of Benefits

Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct, and I request that Medicare, Medicaid, Medigap, and supplementary insurance companies make payments of authorized medical benefits directly to the physicians and medical staff of MEDICAL ARTS NEUROLOGY plus any collection fees, and/ or attorney's fee if applicable.

Guaranty of Payment

I understand that I am financially responsible for payment to the physicians and medical staff of MEDICAL ARTS NEUROLOGY for any changes not covered or allowable by my insurance company and all applicable out of pocket expenses, including deductibles, co-insurance, and co-payments. I further understand and agree that if this account is placed for collection. I will be responsible for paying balance owed to the physicians and medical staff of MEDICAL ARTS NEUROLOGY plus any collection fees, and / or attorney's fee if applicable.

Patient Financial Information

Please be advised that if you insurance plan requires previous authorization it must be obtained prior to seeing the doctor, we cannot request authorization/referrals at the time of the visit. All out of pocket expenses such as deductibles, co-payments, etc. are due at the time of registration, prior to the office visit. ***Higher co-payments and/ or deductibles may apply if our physician is not a network participating provider with your insurance plan.***

Third Party Benefit Collections

I hereby authorize MEDICAL ARTS NEUROLOGY to act on my behalf as attorney in fact in (1) the collection of benefits from any responsible third party payer through any legal means necessary, and (2) in endorsement of benefit checks made payable to myself or physicians and medical staff of MEDICAL ARTS NEUROLOGY.

I, _____ (PRINT NAME) ACKNOWLEDGE THAT THIS FORM HAS BEEN EXPLAINED TO ME AND THAT I HAVE READ AND UNDERSTAND EACH OF THE PROVISIONS APPEARING ON THIS FORM, AND THAT BY SIGNING THIS FORM, I CONSENT TO THESE PROVISIONS INDIVIDUALLY AND COLLECTIVELY.

_____ _____

Patient or Legal Guardian Date

_____ _____

Witness Date

Acknowledgment of Practice's Notice of HIPAA Privacy

I have been presented with and reviewed the terms of this notice and understand that I may request a copy of this notice at any time.

Name of Patient _____ Date of birth _____ Signature of Patient _____ Date _____

I designated the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. The persons below will only have contact with the practice upon my request (i.e. if I ask the persons below to call the office or I contact the office and ask the persons below be contacted). I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print name: _____ Telephone: _____

Print name: _____ Telephone: _____

Print name: _____ Telephone: _____

The following person(s) are **NOT** authorized to receive my Patient Health Information:

Print name: _____

Print name: _____

Designation of Certain Relatives, Close Friends, and Other Caregivers:

I agree that the practice may disclose certain aspects of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my healthcare. In that case, the practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I wish to be contacted in the following manner (check all that apply):

Telephone: _____

Fax communication: _____

Written communication: _____

Please provide address if different from registration:

_____

_____

_____ Ok to leave message with non-clinical information _____ Ok to mail to my home address

_____ Leave message with a call back number only