ST. AUGUSTINE NEUROLOGY
REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Social Security Number

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Cell phone number:	Home phone no.:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Phone number:

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell phone #.:	Home phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ST. AUGUSTINE NEUROLOGY or insurance company to release any information required to process my claims.

_____ _____

Patient signature ***Date***

St. Augustine Neurology, PA

Your Name_____ DOB:_____

Who referred you to us: _____

Were you involved in a **car accident or workman comp claim**? If so date of accident?

_____

Are you currently receiving hospice care? _____

For what problem were you referred to us? _____

Describe your symptoms: _____

_____

Please list all medical conditions _____

_____

_____

Please list all major surgeries you have had: _____

_____

_____

Describe any known allergies to medication, contrast dye and others: _____

_____

Has anyone in your family ever had a brain tumor, seizures or epilepsy, dementia, Parkinson's, multiple sclerosis, muscle disease, neuropathy, other neurological disorder? If yes, please describe and give relationship of family members: _____

Any other medical problems run in your family? _____

Do you use tobacco products? If yes, describe how long and how much:

_____

Do you consume alcohol? If yes, what/how much per week: _____

Do you have children? _____ Marital Status? _____

Whom do you live with? _____

Do you have a job? YES / NO, If yes, please describe_____ _____ _____

Are you receiving disability? YES / NO _____

Are you pregnant, planning pregnancy, or breastfeeding? _____

LIST CURRENT MEDICATIONS (if you have a list, you can provide to us w/o listing here)

_____

_____

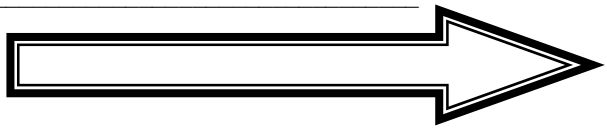
_____

_____

_____

_____

MORE ON BACK



St. Augustine Neurology, PA

Your Weight_____ Height_____

Do you have the following health conditions? Please answer Y or N

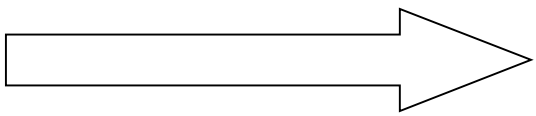
Kidney disease Liver disease Peptic ulcer Diabetes

Heart disease Hypertension HIV Hepatitis C Pacemaker

If you have a pacemaker, is it MR compatible? (please provide a copy of the card)

REVIEW OF SYSTEMS:	***Y/ N***		***Y/N***
Do you have a headache?		Do you have sinus congestions?	
Do you have seizures?		Do you have hearing loss?	
Have you ever lost consciousness for other reasons?		Do you have ringing in ears?	
Do you have tremors?		Do you have chest pains?	
Do you have weakness?		Do you have palpitations?	
Do you have numbness?		Have you lost your appetite?	
Do you have dizziness?		Have you lost weight unexpectedly?	
Do you have double vision?		Do you have indigestion or heartburn?	
Do you have blurred vision?		Do you have stomach pains?	
Do you have confusion?		Do you have constipation or diarrhea?	
Do you have memory loss?		Do you have nausea or vomiting?	
Do you have trouble walking?		Do you have burning while urinating?	
Can you take care of yourself?		Do you have blood in your urine?	
Do you fall?		Do you wake up at night to urinate?	
Do you feel depressed?		Do you have to rush to urinate?	
Do you have sleeping problems?		Do you lose control over urinating or stool?	
Do you feel anxious?		Do you have erectile dysfunction?	
Do you have hallucinations?		Do you have fevers?	
Do you have a cough?		Do you have night sweats?	
Do you cough up thick mucus?		Do you have fatigue?	
Have you coughed up blood?		Do you have neck pain?	
Do you have shortness of breath?		Do you have back pain?	
Do you have a rash?		Do you have joint pains? Where? _____	

MORE ON BACK



Patient Signature:_____ Date: _____

ST. AUGUSTINE NEUROLOGY, PA

HIPAA Privacy and Office Policy

I understand that my personal and health information provided to this office is protected by the HIPAA law (Health Insurance Portability and Accountability Act of 1996 Public Law 104-191 which is available on-line). It will be used only for my diagnosis and treatment, payment, and related healthcare operations. Without my permission, my information will not be used for other purposes.

With my consent, St. Augustine Neurology, *PA* may mail or fax to my home or other designated location any item that is needed for carrying out treatment, payment, and other healthcare operations. These include office appointment reminders, insurance items, or any call pertaining to clinical care (e.g., lab and imaging results).

I understand that all forms in my medical record including those that I sign will be scanned into electronic medical record and thus be rendered as the "original document" for any audit and legal purposes.

I will allow St Augustine Neurology, PA to communicate with me by mail, email, fax, texting or phone call unless specified at the end of this line. (I do not wish to be contacted by _____).

I understand that St Augustine Neurology, PA has the right to refuse rendering service due to disrespect to members of this office.

If I do not sign this consent, St. Augustine Neurology, PA may decline providing service to me.

I understand that while this office will bill my insurance, however, I need to pay my portion including copay, co-insurance, or deductible at the time of service. I also agree that I am ultimately responsible for services provided to that is not covered by my insurance.

Appointment cancellation: If I cannot keep my scheduled appointment, I am required to cancel it at least 24 hours in advance. Otherwise, I agree to pay $50.00 for no-show fee. I understand that the office may call me to remind me of the upcoming appointment only as a courtesy but not required. I am responsible for keeping track of my appointment.

PRINTED NAME_____

SIGNATURE _____ DATE_____

Persons authorized to access my medical record/information (name and relation)

_____ _____