

**The Neurology and Electromyography Clinic, P.A., dba
The Neurology Clinic, P.A.**

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General Information:

Thank you for choosing The Neurology Clinic! Our primary mission is to provide high quality, caring, and personal medical service in an efficient and pleasant atmosphere. We provide comprehensive adult neurology services with emphasis on specialized EMG testing of the peripheral nerves and muscles.

The Staff of The Neurology Clinic is committed to providing you with the highest quality specialty care. Enclosed in this packet is the information you need to assist you in preparing for your appointment. Completion of the enclosed forms is essential to maximizing the benefits of the services you receive from us.

When you arrive for your appointment please provide us with the following:

- 1) Copies of medical records, X-rays, and your medication list
- 2) Your completed Patient Registration Form (enclosed)
- 3) Your completed Patient Medical Information Form (enclosed)

We look forward to being of service to you. Thank you again for choosing The Neurology Clinic.

The Neurology Clinic, P.A.

Patient Medical Information Form

Your name: _____

Date of Birth: _____

Please circle the symptoms that you are experiencing:

Constitutional:	Weight gain	Weight loss	Fatigue	Insomnia	Fevers
	Poor Memory	Confusion	Dizziness		
Eyes:	Double vision	Blurred vision	Visual loss	Dry eyes	Droopy eyelids
Ears:	Ringin in ears	Hearing loss	Fullness in ears	Vertigo	
Throat:	Dry mouth	Difficulty chewing	Painful swallowing	Difficulty swallowing	
GI:	Nausea	Vomiting	Diarrhea	Constipation	
GU:	Impotence	Loss of stool	Loss of urine	Frequent urination	
Muscular:	Back pain	Neck pain	Limb pain	Stiffness	Spasms and cramps
Neurological:	Headache	Passing out	Weakness	Shaking	Twitching
	Poor balance	Falling	Numbness	Tingling	Clumsiness
Do you feel:	Down, sad	Nervous	Anxious	Paranoid	

Do you have a past history of any of the conditions listed below:

	Yes	No		Yes	No		Yes	No
Diabetes	___	___	Heart attack	___	___	Liver problems	___	___
High blood pressure	___	___	Heart arrhythmia	___	___	Kidney problems	___	___
Thyroid disease	___	___	Heart valve problem	___	___	Lung problems	___	___
Stroke	___	___	Arthritis	___	___	Drug/alcohol abuse	___	___
Stomach ulcers	___	___	Back trouble	___	___	Mental disease	___	___
Cancer	Yes	No	If yes, what type and treatment _____					
List any other medical illnesses not indicated above: _____								
List surgeries: _____								
Do you smoke	Yes	No	If yes: packs per day _____		How many years _____			
Do you drink alcohol	Yes	No	If yes: what kind _____		How much a week _____			

<u>Family History:</u>	Medical Problems	Cause of Death	Age at Death
Siblings:	_____	_____	_____
Mother:	_____	_____	_____
Father:	_____	_____	_____
You are: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed			
Highest level of schooling completed: _____		Do you have children: ___ Yes ___ No	

Release of Medical Records & Assignment of Benefits:

I hereby authorize The Neurology Clinic, P.A. to release my medical records to my insurance carrier or similar organization for verification of my medical claim(s). I hereby authorize my insurance benefits to be paid to The Neurology Clinic, P.A.

Print your name: _____ Signature: _____

Reviewed by Physician: _____ Date: _____

The Neurology Clinic, P.A.

Patient Registration Form

Patient Name: _____ **Date of Birth:** _____
Street Address: _____ **City:** _____
State: _____ **Zip:** _____ **Phone (H):** _____ **(W):** _____
Social Security #: _____ **Marital Status:** _____ **Gender:** _____
Driver's License #: _____ **Occupation:** _____
Employer Name: _____ **Employer Phone:** _____
Employer Address: _____

Spouse's Name: _____ **Date of Birth:** _____
Social Security #: _____ **Employer Name:** _____

Guarantor/Guardian Name: _____ **Date of Birth:** _____
Street Address: _____ **City:** _____
State: _____ **Zip:** _____ **Phone (H):** _____ **(W):** _____
Employer Name: _____ **Relationship to Patient:** _____

Please list a person living outside your home who should be notified in case of emergency:

Name: _____ **Phone:** _____

Primary Insurance Company Name: _____ **Phone:** _____
Insurance Company Street Address: _____
City: _____ **State:** _____ **Zip:** _____ **Name of Insured:** _____
Relationship to Patient: _____ **ID#:** _____ **Group#:** _____
Has your annual deductible been met? Yes _____ **No** _____ **Remaining Balance (if applicable)** _____

Secondary Insurance Company Name: _____ **Phone:** _____
Insurance Company Street Address: _____
City: _____ **State:** _____ **Zip:** _____ **Name of Insured:** _____
Relationship to Patient: _____ **ID#:** _____ **Group#:** _____

I agree that (regardless of my insurance policy) I am responsible for the entire balance on my account resulting from professional services provided to the patient (or myself). I will be responsible for all payments not paid by my insurance company, HMO, or PPO. I have read the information in the Financial Policy and completed the above registration. The information provided is, to the best of my knowledge, correct and true. I will notify this office of any changes in any of the above information.

Signature: _____ **Date:** _____

