THE NEUROLOGY CENTER OF SOUTHERN CALIFORNIA

Account #_____

PATIENT REGISTRATION

Please answer all questions completely. **PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED**

Date_____ ☐**New** ☐**Update**

Name_____ Date of Birth _____ ☐ Male ☐ Female
Last First Middle

Home Address_____

City/State/Zip _____

Phone (_____) _____

Cell (_____) _____

Patient's Soc. Sec. # _____

Driver License No/State _____

Race __White/Caucasian __ Black or African American __ Asian __ American Indian __ Native Hawaiian or Other Pacific __ Decline to State

Ethnicity __ Hispanic or Latino __ Not Hispanic or Latino __ Decline to State

Primary Language Spoken _____

Employer_____ Employer's Address_____

Who is your Primary Care Physician? _____Referring Physician?_____

PATIENT'S E-MAIL ADDRESS _____

Financially Responsible Party (subscriber info)

If other than self _____Relationship _____

Address _____ Phone (____)_____
Number Street City

Patient's Primary Insurance _____ **Subscriber's Social Security #**_____

Subscriber ID #_____ **Subscriber's Group ID#** _____ **DOB** _____/_____/_____

Patient's Secondary Insurance _____ **Subscriber's Social Security #**_____

Subscriber ID #_____ **Subscriber's Group ID#** _____ **DOB** _____/_____/_____

Subscriber to Secondary Insurance _____**Relationship to Patient**_____

Emergency contact_____ Relationship _____
Last Name First Middle

☐ **Please check box if authorized to release appointment/medical information.**

Address _____ Phone (_____)_____
Number Street City

I have read and understand all of the above and hereby give my consent for medical treatment.

I understand that I am responsible for my bill.

I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.

_____ _____

Patient's Signature **Date**

31515 Rancho Pueblo Road, Suite 104, Temecula, CA 92592
6010 Hidden Valley Road, Suite 200, Carlsbad, CA 92011
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Account #_____

PERMISSION TO FURNISH MY MEDICAL INFORMATION

Patient Name: _____

1. FURNISH TO RELATIVES AND/OR PERSONAL ASSOCIATES

I hereby give my consent to The Neurology Center to furnish medical information about me (e.g., blood test results, other test results, doctor's instructions, etc.) in the event I am not immediately available.

Approved Person(s)	Relationship to Patient
_____	_____
_____	_____
_____	_____

- ❑ I hereby authorize The Neurology Center to disclose medical information in the purpose to contact me with routine results and to remind me of my future appointments. You may email, send text messages and or leave this information on my answering machine.
- ❑ I hereby instruct The Neurology Center to furnish information **only** to me. In this instance, I understand you will leave a message for me to call the office if I am not immediately available.
- ❑ Other special instructions regarding furnishing my medical information: _____

_____

_____

x_____ _____ _____

Patient Signature **Date** **Designated Power Of Attorney**

2. FURNISH TO PHYSICIANS OR OTHER MEDICAL PROVIDERS

I understand that The Neurology Center will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc.) **about me with my Primary Care Physician and/or the Provider or entity that referred me to The Neurology Center.**

In addition, I hereby give my consent to The Neurology Center to furnish and/or discuss my medical information with the following additional Medical Providers or Entity(ies)

Providers Name	Phone Number	City
_____	_____	_____
_____	_____	_____
_____	_____	_____

x_____ _____ _____

Patient Signature **Date** **Designated Power Of Attorney**

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NEW PATIENT HISTORY

Name _____ **Birthdate** _____ **Date** _____

Age: _____ I am: □ Right Handed □ Left Handed □ Ambidextrous

Referring Physician: _____

What is your primary language spoken? _____

How do you prefer to receive information about your diagnosis? ___Verbal ___Written ___Pictures

Chief Complaint
Please list the main problems, which bring you to the doctor

1. _____

2. _____

3. _____

4. _____

Please describe the problems:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Account #_____

Review of Symptoms

Check boxes if you are having any of these symptoms; write in details:

Constitutional
- □ Chills
- □ Fatigue
- □ Changes in Weight

Eyes
- □ Double vision
- □ Eye Pain
- □ Blurred vision

Ears, Nose and throat
- □ Hearing loss
- □ Ringing
- □ Dizziness
- □ Sore throat

Cardiovascular
- □ Ankle swelling
- □ Night sweats
- □ Chest Pain or Pressure
- □ Skipped beats
- □ Blackouts

Respiratory
- □ Cough
- □ Shortness of breath
- □ Hyperventilation

Gastrointestinal
- □ Abdominal Pain
- □ Appetite loss
- □ Blood in stool
- □ Constipation
- □ Diarrhea
- □ Nausea
- □ Vomiting

Hematologic/Lymphatic
- □ Easy bruising or bleeding
- □ Anemia

Musculoskeletal
- □ Joint stiffness
- □ Joint swelling
- □ Joint Limitation
- □ Joint pain
- □ Neck pain
- □ Back pain

Genitourinary
- □ Blood in urine
- □ Burning with urination
- □ Hesitancy
- □ Night time frequency
- □ Difficulty with urination

Skin/Breast
- □ Rashes
- □ Nipple discharge

Endocrine
- □ Intolerant of heat or cold
- □ Excessive urination
- □ Excessive hunger
- □ Increased thirst

Allergic/Immunologic
- □ Allergies to medication, Iodine, shellfish,

Neurological
- □ Difficulty with speech
- □ Impaired memory
- □ Confusion
- □ Headaches
- □ Seizures
- □ Blackouts
- □ Fainting
- □ Trouble swallowing
- □ Arm pain
- □ Leg pain
- □ Weakness or paralysis
- □ Tremors
- □ Incoordination
- □ Uncontrolled movements
- □ Stroke
- □ Imbalance
- □ Numbness
- □ Tingling

Psychiatric
- □ Mood swings
- □ Depression
- □ Anxiety
- □ Memory
- □ Hallucinations

Current height _____ Current weight _____

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Account #_____

Patient Name: _____

Past Medical History

Check if you have had any of these problems. Give details.

- □ Angina
- □ Asthma
- □ Blindness, part or full
- □ Cancer
- □ Depression
- □ Diabetes
- □ Dizziness
- □ Double vision
- □ Fainting
- □ Head trauma
- □ Headache
- □ Hearing problem
- □ Heart attack
- □ Heart failure
- □ Hepatitis
- □ Herniated disc
- □ High blood pressure
- □ High cholesterol
- □ Irregular heart beats
- □ Nervous breakdown
- □ Numbness
- □ Polio
- □ Psychiatric conditions
- □ Sciatica
- □ Seizures (epilepsy)
- □ Speech problems
- □ Stroke
- □ Swallowing problems
- □ Ulcers
- □ Venereal infections
- □ Vertigo
- □ Walking problems

Have you had any of these tests? Give details.

- □ Angiogram of the brain
- □ CAT scan
- □ EEG (brain wave test)
- □ EMG (nerve-muscle test)
- □ Spinal tap
- □ Skull X-ray
- □ Spine X-ray
- □ Magnetic Resonance (MRI)

Medications – Please list all of the medications you are currently taking. Include aspirin, birth control pills hormones, water pills, sleeping pills, tranquilizers, vitamins, etc.

Medication	Dosage	How often taken?	For how long have you taken it?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Surgical Procedures – List chronologically

Operations	Hospital & City	Date
1.		
2.		
3.		

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Patient Name: _____

Other Hospitalizations or Other Medical Problems

1.	
2.	
3.	
4.	

Allergies:
Please list any allergies to medications _____

Are you allergic to X-ray dye? _____

Are you allergic to shellfish? _____

Social History
Your place of birth: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed

Education Completed: (YEARS) □ 9 □10 □11 □12 □13 □14 □15 □16 □ 16+

Occupation: _____

Do you exercise regularly? □ Yes □ No, if so what do you do? _____

Habits
Check any of the following that you have used and state amount:
□ Caffeine How much per day? _____
□ Alcohol How much per day? _____
□ Tobacco How much per day? _____

Family History
Have any of your relatives has any of the following? If yes, indicate relationship (e.g., father):
Check if positive **Relationship**
□ Alcoholism _____
□ Cancer _____
□ Diabetes _____
□ Heart Disease _____
□ Mental Illness _____
□ Migraine _____
□ Seizures _____
□ Stroke _____
□ Tuberculosis _____

Are there any other diseases that run in the family? _____

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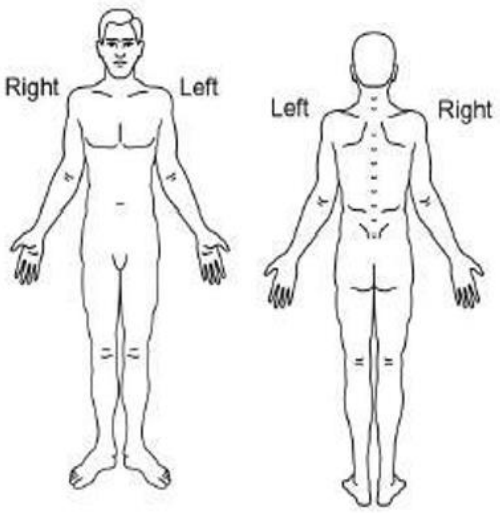
Patient Name: _____

What is your chief complaint for which you are being seen in Pain Management Clinic?

_____

On the diagram, mark the areas you are experiencing pain. Use the following symbols to describe your pain:
Aching: **A** Burning: **B** Cramping: **C**
Numbness: **N** Pins & Needles: **P** Stabbing: **S**
Put an **X** on the area that hurts the most.



How long ago did your symptoms start?

_____

How often do you have symptoms?
□ All the time □ Sometimes

If sometimes, how long does your pain last?
_____Minutes _____Hours _____Days

Using the pain scale below, please answer the questions:
What is your pain score right now?_____/10
How bad does it get?_____/10
What is the lowest?_____/10

What medications for pain do you take? Helpful?
_____ □ Yes □ No
_____ □ Yes □ No
_____ □ Yes □ No

What activities worsen your symptoms?
Please circle:
Sitting, standing, walking, lifting, driving, exercise
Other:_____

What activities improve your symptoms?
Please circle:
Sitting, standing, walking, lying, exercise
Other:_____

Any history of:
Cancer? □ Yes □ No
Unexplained weight loss? □ Yes □ No

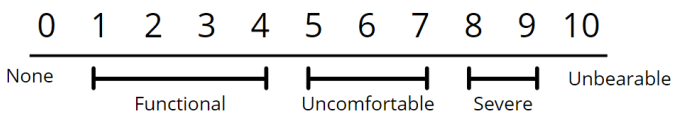
Have you had spine surgery? □ Yes □ No
If yes, when was your operation(s)? _____

What treatments have you had? Was it helpful?
□ Physical Therapy □ Yes □ No
□ Ice or Heat □ Yes □ No
□ TENS Unit □ Yes □ No
□ Acupuncture □ Yes □ No
□ Massage Therapy □ Yes □ No
□ Chiropractor □ Yes □ No
□ Yoga or Pilates □ Yes □ No
□ Spine Injections □ Yes □ No

Are you employed? □ Yes □ No
If yes: □ Full-time □ Part-time
What do you do? _____
What city do you live in? _____

Do you smoke? □ Yes □ No
How much do you smoke? _____#years?_____
Have you ever smoked in the past? □ Yes □ No
Date(s) quit? _____
Alcohol use: None _____Drinks per_____
Illegal drugs: None _____Type

Over the past two weeks, have you been bothered by:
Feeling down, depressed, or hopeless? □ Yes □ No
Little interest or pleasure in doing things? □ Yes □ No
Difficulty sleeping at night? □ Yes □ No



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Sleep Survey

Name: _____ DOB: _____

Do you snore?	**Yes ____**	**No ____**
Do you feel tired, fatigued or sleepy during the day?	**Yes ____**	**No ____**
Has anyone observed you stop breathing while you sleep?	**Yes ____**	**No ____**
Do you nap during the day?	**Yes ____**	**No ____**

Do you have any of the following?

Heart Disease	□ Yes	□ No
History of Stroke	□ Yes	□ No
High Blood Pressure	□ Yes	□ No
Depression	□ Yes	□ No
Morning Headaches	□ Yes	□ No
Trouble with Memory Or Concentration	□ Yes	□ No

Sleep Orders
For Office Use Only

- □ **Sleep Consult**
- □ **PSG**
- □ **CPAP Titration Study**

_____
Physician Signature

Did you need any assistance filling out this form? _____Y _____N_____
Signature _____Date _____

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