



Account # \_\_\_\_\_

# PATIENT REGISTRATION

**Please answer all questions completely.**

**PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED**

Date \_\_\_\_\_

New

Update

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  
Last First Middle  Female

Home Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_

Patient's Soc. Sec. # \_\_\_\_\_

Driver License No/State \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_ Referring Physician? \_\_\_\_\_

PATIENT'S E-MAIL ADDRESS \_\_\_\_\_

<b>Race</b>	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian
	<input type="checkbox"/> American Indian	<input type="checkbox"/> Native Hawaiian or Other Pacific	
	<input type="checkbox"/> Decline to State		

<b>Ethnicity</b>	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino
	<input type="checkbox"/> Decline to State	

<b>Primary Language Spoken</b>	_____
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## 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**

6010 Hidden Valley Road, Suite 200, Carlsbad, CA 92011  
31515 Rancho Pueblo Road Ste.104, Temecula, CA 92592  
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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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## 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
- Nighttime 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 \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Past Medical History**

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

- |   |   |
|---|---|
| <input type="checkbox"/> Alcoholism                 | <input type="checkbox"/> Heart Disease                  |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> High Blood Pressure            |
| <input type="checkbox"/> Atrial Fibrillation        | <input type="checkbox"/> High Cholesterol               |
| <input type="checkbox"/> Blindness, part or full    | <input type="checkbox"/> Headache                       |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Multiple Sclerosis             |
| <input type="checkbox"/> Concussion                 | <input type="checkbox"/> Myopathy or Muscular Dystrophy |
| <input type="checkbox"/> COPD                       | <input type="checkbox"/> Neuropathy                     |
| <input type="checkbox"/> Double vision              | <input type="checkbox"/> Parkinson's Disease            |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Seizure (Epilepsy)             |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Diabetes                   |   |
| <input type="checkbox"/> Dementia                   | <input type="checkbox"/> Substance Abuse Disorder       |
| <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> _____                          |
|   | <input type="checkbox"/> _____                          |

**Allergies:**

Please list any allergies to medications \_\_\_\_\_

Are you allergic to X-ray dye? \_\_\_\_\_

Are you allergic to shellfish? \_\_\_\_\_

**Medications** – Please list all 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.		

**Patient Name:** \_\_\_\_\_

**Other Hospitalizations or Other Medical Problems**

1.	_____
2.	_____
3.	_____
4.	_____

**Have you had any of these tests? Give details.**

- Angiogram of the brain
- EEG (brain wave test)
- EMG (nerve-muscle test)
- CAT scan
- Magnetic Resonance Imaging (MRI)

**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                       | <b>Relationship</b> |
| <input type="checkbox"/> Alcoholism     | _____               |
| <input type="checkbox"/> Cancer         | _____               |
| <input type="checkbox"/> Diabetes       | _____               |
| <input type="checkbox"/> Heart Disease  | _____               |
| <input type="checkbox"/> Mental Illness | _____               |
| <input type="checkbox"/> Migraine       | _____               |
| <input type="checkbox"/> Seizures       | _____               |
| <input type="checkbox"/> Stroke         | _____               |
| <input type="checkbox"/> Tuberculosis   | _____               |

Are there any other diseases that run in the family? \_\_\_\_\_

Did you need any assistance filling out this form?     Y     N \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# 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 \_\_\_\_

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## Do you have any of the following?

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| <b>Heart Disease</b>                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>History of Stroke</b>                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>High Blood Pressure</b>                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Depression</b>                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Morning Headaches</b>                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Trouble with Memory Or Concentration</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

<b>Sleep Orders For Office Use Only</b>	
<input type="checkbox"/>	<b>Sleep Consult</b>
<input type="checkbox"/>	<b>PSG</b>
<input type="checkbox"/>	<b>CPAP Titration Study</b>

\_\_\_\_\_  
**Physician Signature**



Account # \_\_\_\_\_

# Pain Survey

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Do you have chronic pain and/or are you interested in seeing our interventional spine and pain specialist to learn about non-opioid medication treatments?**

Yes \_\_\_\_\_ No \_\_\_\_\_



\_\_\_\_\_  
**Physician Signature**

**Was a pain consult ordered?** Yes \_\_\_\_\_ No \_\_\_\_\_

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