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**

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Welcome to The Neurology Center

STATEMENT OF FINANCIAL POLICY
This facility will bill your insurance and receive payment directly from them. Any services that your insurance will not cover are your responsibility. If for any reason you are not able to pay your co-payment at the time of service an additional $15.00 will be added to your statement.

If you have HMO insurance, it requires authorization for any treatment in our office. If this authorization has not been obtained before your visit, you will be required to sign a financial waiver. You will be expected to pay for all charges incurred, and if your insurance subsequently authorizes the services, your payment will be refunded upon receipt of insurance payment.

If we are not a participating provider for your insurance plan, we will bill your insurance as a courtesy, if you have provided us with complete information to do so.

If you do not have insurance, payment is expected at the time of service. We accept Visa, MasterCard and American Express for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Business Office upon your request.

If you need our doctor to complete forms such as disability or Department of Motor Vehicles, there will be a $35 fee per form to be completed. ** ***Form fee may vary*** **
Statements are mailed monthly to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact the Billing Office at (760) 631-3020 to make payment arrangements.

New patients: A 24-hour advanced notice is required if you must cancel or change your appointment. If you miss your initial appointment without notifying our office, we will notify your referring provider and make an attempt to schedule another appointment. If a second appointment is missed with no notification, we will ask that you be referred to another provider.

For established patients who miss an appointment without giving a 24-hour advanced notice, there is a $75.00 charge for general office visits, and a $200.00 charge for all missed diagnostic testing or study appointments. **Our policies are created to allow for effective scheduling and to ensure all patients wishing to be seen may be accommodated. Please help us better serve you by notifying us as soon as possible if you must change or cancel your appointment.**

LAB TEST, CAT SCANS, MRI'S, ETC:
When referred to an outside facility, please contact your insurance to ensure it is a contracted facility, in orders to keep your costs down. ***Ultimately, it is your responsibility to know your insurance plan benefits.***

****Please note that our office does not call patients with normal test results. All normal test results will be reviewed during follow up office visit. If you wish to get your results prior to your next appointment please call our office at 760-631-3000 option 4.** ***
Prescription Refills:

Account #_____

Please call your pharmacy for prescription refills, at least 4 to 5 days before you run out of medication. Our doctors cannot authorize refills after office hours or on weekends, as they cannot access your medical records. Refills requested after hours will be reviewed for refill, on the next business day, and may take up to 48 hours to fill. Refills can take up to 4 days if we have to request authorization from your insurance as we have to wait for the approval before we can call pharmacy.

We provide medical records to other medical providers.

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

HIPAA Notice of Privacy Practices – Acknowledgement of Receipt and Consent to Disclosure 14712

The Neurology Center of Southern California participates in an Organized Health Care Arrangement (OHCA) with the University of California, San Diego Health System (UCSD) for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice is jointly used by and jointly describes the practices of all participants with the OHCA, including, without limitation any health care professional authorized to enter information into your medical record. UCSD also has its own Notice of Privacy Practices that can be access at http://health.ucsd.edu/hipaa/Pages/hipaa.aspx.
The OHCA will follow the terms of this joint notice. The OHCA may share medical information with each other for treatment, payment, or health care operations related to the OHCA as well as for research related purposes conducted at UCSD and at all related UC Medical Groups and UC Hospitals."

I have read and understand The Neurology Center's financial and claims filing policies.
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 and consent to having my insurance payor billed.
I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.

Patient's Signature_____

Responsible Parties Signature (if other than patient)

_____

Thank you for choosing The Neurology Center!

THE NEUROLOGY CENTER OF SOUTHERN CALIFORNIA

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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Account #_____

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 _____

THE NEUROLOGY CENTER OF SOUTHERN CALIFORNIA

Account #_____

Patient Name: _____

Past Medical History

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

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

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: _____

THE NEUROLOGY CENTER OF SOUTHERN CALIFORNIA

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Other Hospitalizations or Other Medical Problems

1.	
2.	
3.	
4.	

Have you had any of these tests? Give details.

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

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?_____

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

Signature _____Date _____

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Account #_____

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

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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 _____

_____ Was a pain consult ordered? Yes ____ No ____

Physician Signature

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THE NEUROLOGY CENTER OF SOUTHERN CALIFORNIA

Account #_____

Patient Name: _____

FOR HEADACHE/MIGRAINE PATIENTS ONLY
PLEASE STOP HERE IF YOU ARE NOT BEING SEEN FOR HEADACHES/MIGRAINES

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

1. When did you first start having any kind of headache? _____
2. How frequent were your headaches initially? _____
3. When did you first start having any kind of severe headache? _____
4. How many headaches of any kind do you experience on average per month in the last year? _____
5. How long have they been this frequent? _____
6. On average how many days a month are you completely headache **FREE (no pain)**? _____
7. On average how many moderate to severe headaches do you experience per month? _____
8. How long do your moderate to severe headaches typically last? (Circle)
   No more than: Minutes 3 hours 4 hours 24 hours 2days 1 week or longer
8. How painful are your headaches? (1 is mild and 10 is severe and disabling) (Circle)
   1 2 3 4 5 6 7 8 9 10
9. Where are your headache typically located? (Check all that apply)

Behind the eye	___Right ___ Left	Temple	___Right ___ Left
Forehead	___Right ___ Left	Side of the head	___Right ___ Left
Back of head	___Right ___ Left	Neck	___Right ___ Left

   Whole head _____
10. How would you describe your headache character?
    Throbbing Stabbing Pressure Burning Tightness Dull Sharp Other
11. Do any of the following symptoms occur before or during your headaches? (Circle all that apply)
    Nausea Vomiting Sensitive to light Sensitive to noise Sensitive to smell
    Blurred or Double vision Loss of vision Flashing, sparkling, colored lights in eyes
    Eye lid droop Eye tearing Dizziness Difficulty concentrating
    Speech difficulty Numbness/tingling Weakness of face, arm or leg
    Other _____
12. Do any of the following trigger your headache or make them worse? (Circle all that apply)
    Exercise Increased stress Lack of sleep Weather change/Storm Bright light Loud noise
    Fatigue Missing a meal Strenuous activity Certain smells or perfume Coughing/sneezing
    Bending over Sexual activity Dehydration Eye strain Caffeine/Lack of Caffeine Alcohol: wine, beer, or liquor
    Foods: chocolate, cheese, MSG, gluten or other _____

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Patient Name: _____

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

13. If you are female, did or do your headaches change with the following? (Circle all that apply)
    Menstrual cycle Birth control Pregnancy Menopause Other hormonal medications

14. Do your headaches ever awaken you in the middle of the night or present upon awakening in the morning? (Circle)
    Night: Occasionally Often
    Morning: Occasionally Often

15. Do any of your family members have headaches? No Yes If yes, who? _____

16. Do you have a history of:
    Anxiety Depression Trouble sleeping Irritable Bowel Syndrome Fibromyalgia Chronic Fatigue Seizure Disorder Bipolar Disorder Restless Leg Syndrome

17. List the testing you have had for your headaches (MRI, CT, spinal puncture): If yes, please provide the facility name:

    _____

    _____

    _____

    _____

18. How many days a week do you use medication for acute treatment of headache (prescription or over the counter)? _____

19. Which medication(s):

    _____

    _____

    _____

    _____

20. How long have you been using that amount of medication for acute treatment? _____

21. How many times in the **last year** did you go to the ER because of headaches?
    0 1-2 3-4 5+

THE NEUROLOGY CENTER OF SOUTHERN CALIFORNIA

Account #_____

Patient Name: _____

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

Medications you have tried

ABORTIVE AGENTS		PROPHYLACTIC AGENTS
Over the counter		**Anti-Depressants**
Ibuprofen	Aleve – naproxen	Elavil- amitriptyline
Excedrin	Tylenol	Pamelor- nortriptyline
BC Powder		Vivactil- protriptyline
		Prozac- fluoxetine
Triptans		Paxil- paroxetine
Imitrex- sumatriptan (pill, nasal spray, or injection)		Effexor- Venlafaxine
Treximet – Imitrex/naproxen		Cymbalta - Duloxatine
Maxalt- rizatriptan		**Seizure Medications**
Relpax- eletriptan		Topamax- topiramate
Zomig- zolmitriptan (pill or nasal spray)		Zonegran- zonisamide
Axert- almotriptan		Depakote- divalproex or valproic acid
Amerge- naratriptan		Neurontin- gabapentin
Frova- frovatriptan		Lamictal- lamotrigine
		Lyrica- pregablin
Other Pain Relievers		
Fioricet- butalibital/acetaminophen/caffeine		**Blood pressure medication**
Fiorial- butalibital/aspirin/caffeine		Inderal- propranolol
DHE- dihydroergotoamine		Verapamil
Midrin		Atacand-candesartan
		Atenolol, metoprolol, nadolol, timolol
Narcotics		
Norco, Lortab, Percocet		**Botox Injections**
Oxycodone, Hydrocodone, Dilaudid, Morphine		
Tylenol with Codeine		**Natural Supplements**
		Riboflavin Butterbur
Other NSAID's (Non-Steroidal Anti-inflammatories)		Magnesium Co Q 10
Ketoprofen	Relafen	
Diclofenac (Cambia or Zipsor)	Meloxicam	**Procedures:**
		Accupuncture Chiropractor
Muscle Relaxants		Cefaly band Massage
Norflex	Zanaflex	Occipital Nerve Block SphenoCath
Flexeril-cyclobenzaprine	Baclofen	Transcranial Magnetic Stimulation Device

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Account #_____

FOR SLEEP PATIENTS ONLY

PLEASE STOP HERE IF YOU ARE NOT BEING SEEN FOR SLEEP.

SLEEP MEDICINE HISTORY AND PROFILE QUESTIONNAIRE

Name _____ Date _____

Referring Physician _____ Primary Care Provider _____

Reason for your visit today?

_____

Do you snore? **Yes / No / Don't know** **If yes, circle one of the following:**

Snoring is: Rare 1-2 x/week 3-4 x/week every night

Snoring is: Soft Moderately loud Loud enough to be heard outside bedroom

Snoring is: Only when lying on your backPresent in any position

Does snoring disrupt the bed-partner's sleep? Yes or No

Has anyone told you that you stop breathing during sleep? Yes or No

Any episodes of gasping or choking during sleep? Yes or No

Have you gained weight in the past year? Yes or No If yes, How many lbs? ____

Have you gained weight over the past 5 years? Yes or No If yes, How many lbs? ____

Please circle any symptoms that you experience with your sleep:

Discomfort in legs	Kicking during sleep	Restless sleep
Frequent awakenings	Grinding/Clenching teeth	Frequent (>1) urination at night
Shortness of breath	Excessive perspiration	Racing heartbeat
Morning headaches	Frequent heartburn	Nasal congestion
Dry mouth		

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Sleep Medicine Questionnaire (continued…)

Please answer the following questions if you have previously had a sleep study or have been diagnosed with a sleep disorder. Otherwise, skip to the next section:

Have you ever had a sleep study either at home or in a sleep laboratory facility? Yes or No

If yes, When and Where? _____

Was sleep apnea diagnosed? Yes or No

If yes, please describe: _____

Are you on CPAP? Yes or No If yes, what is your pressure setting? _____

Sleep Schedule:

Bedtime on **weekdays or work days**: _____ Wake up time: _____

Bedtime on **weekends or days off**: _____ Wake up time: _____

Number of naps per week: _____ At what time? _____ How long are the naps?_____

Work hours: _____ Type of work: _____

Any trouble getting to sleep? Yes or No How many times per week? _____

Any trouble staying asleep? Yes or No How many times per week? _____

Do you use sleep aides (prescription or over-the-counter)? Yes or No

Names of the sleep aides and # of times used per week: _____

Caffeinated beverages? Yes or No How many per day?_____ How many total ounces? _____

Do you smoke cigarettes or use nicotine/tobacco products? Yes or No

Do you drink alcohol? Yes or No # of drinks per day? _____ # per week? _____

Circle: wine/beer/other liquor

Do you exercise? Yes or No Type of exercise: _____ Days per week: _____

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Sleep Medicine Questionnaire (continued…)

Epworth Sleepiness Scale

How likely are you to doze off in the following situations? Answer with a number 0 – 3 as indicated below:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation:	**Chance of Dozing:**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes at a stoplight or in traffic	_____

Total Score: _____