PATIENT REGISTRATION FORM

NOVA Neurology Center

PATIENT INFORMATION

Last Name			First Name	MI	Gender □ M □ F
Social Security Number			Date of Birth	Marital Status □ M □ S □ W □ D □ SEP	
Race			Ethnicity □ Hispanic □ Non-Hispanic	Language if other than English	
Home Address			E-Mail Address	**Pharmacy Name/Address**	
			Home Phone		
			Cell Phone		
City	State	Zip	Preferred Method of Communication □ Home Phone □ Cell Phone □ E-Mail	**Pharmacy Phone**	
Employer Name and Address			Work Phone	Emergency Contact Name	
			Primary Physician Name Phone	Emergency Contact Phone	
			Referring Physician Name (if other than Primary) Phone		

INSURANCE INFORMATION

Primary Insurance Name			Secondary Insurance Name		
Address			Address		
Phone			Phone		
Subscriber's Name			Subscriber's Name		
Subscriber's SSN	Date of Birth		Subscriber's SSN	Date of Birth	
Relationship to Patient □ Self □ Spouse □ Child □ Other			Relationship to Patient □ Self □ Spouse □ Child □ Other		
Group Number	ID Number	Effective date	Group Number	ID Number	Effective Date

DISCLOSURE TO FAMILY MEMBERS AND FRIENDS

Please list any person that you would like to grant permission to your provider to discuss your Medical Record and/or Plan of Care

Name	Relationship	Home Phone	Cell Phone
Name	Relationship	Home Phone	Cell Phone

Patient/Guarantor Printed Name _____

Patient/Guarantor Signature _____ Date _____

3 MORE PAGES

PATIENT REGISTRATION FORM

NOVA Neurology Center

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by NOVA Neurology center and/or affiliated medical staff member(s) on behalf of myself and my minor children, including stepchildren
The possibility exists (during treatment) for the healthcare works to become directly exposed to my blood or bodily fluids. In the event of such exposure, State law requires a sample of my blood to be tested for the presence of infectious diseases.

RELEASE OF INFORMATION

_____ **(*initials*)** I hereby authorize the release of any and all medical and/or charge information as is necessary for reimbursement from any third party or governmental agency involved in the payment of my treatment including but not limited to insurance payers, HMOs, workers compensation carriers, Medicare, Tricare and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become part of my medical record.
I hereby authorize a query of medication history and/or formulary information within the Electron Medical record in order for drug eligibility and coverage.

PRESCRIPTION HISTORY CONSENT

_____ **(*initials*)** NOVA Neurology Center uses an electronic medical record system (EMR) in which the physician is able to prescribe medications electronically. I give permission to NOVA Neurology Center to send my prescription(s) electronically. Also, I agree that NOVA Neurology Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

FINANCIAL POLICY

_____ **(*initials*)** I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignment of proceeds from all settlements, judgements or verdicts in favor of the undersigned from third party claims for injuries treated hereunder, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fee's costs and interest) due hereunder is to be made to NOVA Neurology Center for any charges not covered by my insurance, including but limited to co-payments, deductibles and fee for non-covered services. The patient and undersigned guarantor are primarily liable for payment of the patient's account and NOVA Neurology Center will send all appointment reminders and billing information to the person responsible for the payment of my bill.
It is their sole responsibility to comply timely with all requirements, and supply all information and documents necessary to obtain payment of benefits by any third party or governmental entity as listed above. Some insurance plans (i.e. Medicare, Blue Cross, CHAMPUS) require that lab work be billed directly by the laboratory performing the testing. In these instances, a separate statement and bill will be sent from the lab performing the test.
The return check fee is $35.00
Failure to call the office 24hrs prior to your appointment to cancel or re-schedule it will result in a $50.00 charge.

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

_____ **(*initials*)** Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service. The undersigned agree(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not collateral or contingent promise to answer for the debt of another. If payment is not made, I under that NOVA Neurology Center may take action to collect its fees. I agree to pay all costs incurred by NOVA Neurology Center for collecting its fees equal to the thirty percent (30%) of the unpaid bill and if applicable, all attorneys' fees.

ACKNOWLEDGMENTS

_____ **(*initials*)** NOTICE OF PRIVACY PRACTICES. I acknowledge that I have received, have previously received or have been offered but declined to receive the NOVA Neurology Center Notice of Privacy Practices.
_____ **(*initials*)** By providing my E-mail address, I authorize NOVA Neurology Center to use the address for the purpose of communicating health-related information or services. I acknowledge that I may opt-out of such communication at any time and my E-mail information will not be shared with any organization outside of NOVA Neurology Center.
_____ **(*initials*)** It is the patient's responsibility to know their insurance carrier's patient responsibilities and procedures. If proper procedures are not followed, the patient may be liable for full payment of the bill. If the insurance carrier requires a referral and/or prior authorization, contact you primary care physician prior to your appointment. The patient is responsible to verify the referral is valid for the follow-up visits.

Thank you for choosing NOVA Neurology Center as your health care partner

Patient Name (please print) _____

Patient/Guarantor Signature _____ Date _____

MEDICARE PARTICIPANTS ONLY

I request that the payment of authorized Medicare benefits be made on my behalf to NOVA Neurology Center for any services furnished to me. I authorize the holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for payable related services. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____

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HEALTH HISTORY QUESTIONARE

Name (Last, First ,MI) □ M □ F	DOB
Previous/Referring Doctor	Reason for Today's Visit

List your prescribed drugs and over-the-counter drugs such as vitamins and inhalers

Name of the Drug	Strength of Medication	Frequency taken

List any medical problems that other doctors have diagnosed

Allergies to medications

Name of the Drug	Reaction you had

Surgeries

Year	Type of Surgery and Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

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FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	□ M □ F	
Mother				□ M □ F	
Sibling	□ M □ F			□ M □ F	
	□ M □ F			□ M □ F	
	□ M □ F		Grandfather Paternal		
	□ M □ F		Grandmother Paternal		
	□ M □ F		Grandfather Maternal		
	□ M □ F		Grandmother Maternal		

HEALTH HABITS AND PERSONAL SAFETY

Marital Status: □ Single □ Married □ Partnered □ Divorced □ Widowed

Alcohol	Do you drink alcohol?	□ Yes □ No	Tobacco	Do you use tobacco?	□ Yes □ No
	If yes, what kind?			□ Cigarettes pks/day	□ Chew #/day
	How many drinks per week?			□ Cigars #/day	□ Pipe #/day
				□ # of years	□ year quit
Drugs	Do you currently use recreational or street drugs?			□ Yes □ No	
	Have you ever given yourself street drugs with a needle?			□ Yes □ No	

WOMEN ONLY

Are you pregnant or breastfeeding?	□ Yes □ No	Number of Pregnancies	Number of live births

SYMPTOMS EXPERIENCED IN THE PAST 6 MONTHS (CHECK ALL THAT APPLY)

Neurological
- □ Headache
- □ Double Vision
- □ Slurred Speech
- □ Imbalance/Unsteady gait
- □ Falls
- □ Abnormal movements
- □ Tremor
- □ Memory loss
- □ Numbness/Tingling
- □ weakness
- □ Seizure
- □ Cramps/Spasms

General
- □ Fevers
- □ Chills
- □ Night sweats
- □ Excessive fatigue
- □ Weight gain/loss
- □ Trouble sleeping
- □ Trouble staying asleep
- □ vivid dreams

Throat/Sinus
- □ Nasal congestion
- □ Sinus pain
- □ Nose bleeds

Eyes/Ears
- □ Visual loss
- □ Blurred vision
- □ Eye pain
- □ Double vision
- □ Hearing loss
- □ Ringing in ears

Psychiatric
- □ Depression
- □ Anxiety
- □ High levels of stress
- □ Hallucinations
- □ Uncontrollable laughter/crying

Cardiac
- □ Chest pain
- □ Palpitation
- □ Syncope/Passing out
- □ Heart murmur

Urinary
- □ Frequency
- □ Incontinence
- □ Urgency
- □ Incomplete bladder emptying

Neck
- □ Neck stiffness
- □ Swollen lymph nodes

Vascular
- □ Swollen leg(s)
- □ Easy bruising or bleeding
- □ Recent Transfusions

GI
- □ Swallowing difficulty
- □ Constipation
- □ Diarrhea

Pulmonary
- □ Shortness of breath
- □ Dry cough
- □ productive cough

Musculoskeletal
- □ Joint pain
- □ Muscle aches