Gilbert Neurology

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3507 S. Mercy Rd. Ste.101, Gilbert, AZ 85297 7400 S. Power Rd. Ste 120, Gilbert, AZ 85297

Name: _____ **DOB:**_____ **AGE:**____ **Date of appointment:** _____

What is the main problem you are having? _____

Is this due to car accident? ___Y ___N ___**Don't Know** **Is a legal case pending?** ___Y ___N ___**Maybe**

R___ **L**___ **HANDED** **Who referred you to Gilbert Neurology?**_____

Allergies: ☐ No Known Drug Allergies

Include allergies to medications and other medical products (ex: tape, latex and iodine)

Name of medicine or product: **Description of reaction:**

_____ _____

_____ _____

_____ _____

What <u>MEDICINES</u> are you taking? (if you need additional space, please turn page over and use back side)

<u>Name of Medicine</u>	**<u>Dosage</u>**	**<u>Times per Day</u>**
•		
•		
•		
•		

What over the counter vitamins or herbal supplements are you taking?

_____

Have you <u>stopped any medicine</u> recently or used <u>other medicine in the past</u> for this problem?

_____

Do you take birth control pills, patch or implant? **Y** **N** **What?** _____

<u>PAST MEDICAL HISTORY</u> **Check those that apply (active or inactive)**

o Alzheimer's/Dementia	o Diabetes	o Kidney Disorder	o Thyroid Disorder
o Anxiety	o Eye Disorder	o Lupus	o TMJ
o Anemia	o Fibromyalgia	o Multiple Sclerosis	o Stomach Ulcers
o Asthma/Emphysema	o Headache/Migraine	o Neuropathy	o Chronic Pain
o Cancer	o Heart Disorder	o Osteoporosis/Osteopenia	o ___Neck ___Back
Type? _____	o Hepatitis	o Rheumatoid Arthritis	___Other pain:
o Brain Aneurysm	o High Blood Pressure	o Seizures	_____
o Depression	o High Cholesterol	o Stroke/TIA	_____

Other medical conditions: _____

Name:_____ DOB:_____

SURGICAL HISTORY ☐ None

Type of Surgery: Year

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

Do you have any blood related family members with similar problems as you? **Y N**

Do you have any blood related family members with:

- **Autoimmune disease** ☐ **Yes** ☐ **No**
  if yes, who?_____
- **Seizure disorder** ☐ **Yes** ☐ **No**
  if yes, who?_____
- **Stroke** ☐ **Yes** ☐ **No**
  if yes, who?_____
- **Neuropathy** ☐ **Yes** ☐ **No**
  if yes, who?_____
- **Headaches** ☐ **Yes** ☐ **No**
  if yes, who?_____
- **Brain aneurysm** ☐ **Yes** ☐ **No**
  if yes, who?_____

SOCIAL HISTORY:

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

Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes-pks/day_____ ☐ Chew -#/day _____

☐ Number of years_____ ☐ Year quit_____

Do you drink alcohol? ☐ Yes ☐ No How much? _____

What is your occupation or major daytime activity? _____

In the **past 3 months:**
How many visits to the ER/Urgent Care for the reason for your appointment with Gilbert Neurology? _____

If so, what facility? _____

Have you had any testing done already regarding the reason you're visiting Gilbert Neurology?

(ex: MRI, CT, PET Scan, EMG/NCS, X-rays, Ultrasound, Lab work)

Test	**Approximate Date**	**Facility**

Review of Systems History-Please mark any symptoms you have

Patient Name: _____DOB: _____Date: _____

General

☐ Poor Appetite ☐ Trouble Walking ☐ Muscle Cramps ☐ Unintentional Weight Loss
☐ Lack of Sleep ☐ Fatigue/Tiredness ☐ Clumsy ☐ Joint Pains
☐ Cold Hands/Feet ☐ Dull taste/smell

Dermatological

☐ Rash ☐ Dry Skin ☐ Bruise easily ☐ Itching

ENT

☐ Dizziness ☐ Jaw Click ☐ Facial Pain ☐ Ringing in Ears
☐ Double Vision ☐ Poor Hearing ☐ Drooling ☐ Dry Mouth

Cardiac, Circulatory, Respiratory

☐ High BP ☐ Swollen Ankles ☐ Fainting ☐ Shortness of Breath
☐ Chest Pain ☐ Irregular Heart Beat ☐ Palpitations

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Stomach Cramps
☐ Constipation ☐ Diarrhea

Genital and Urinary

☐ Unable to hold urine ☐ Kidney Stones ☐ Hesitancy to Urinate
☐ Frequent urination ☐ Urge to Urinate ☐ Impotence

Pregnancy and Gynecology (women only)

☐ ____# of pregnancies ☐ Hot flashes ☐ Menopause
☐ Irregular Periods ☐ Duration of periods_____# of days

Neurological

☐ Dizziness ☐ Weakness ☐ Tremor ☐ Seizures
☐ Poor Memory ☐ Numbness/Tingling

Musculoskeletal

☐ Back Pain ☐ Swelling of joints ☐ Muscle or joint pain ☐ Stiffness

Psychiatric

☐ Anxiety or tension ☐ Depression ☐ Stress ☐ Moodiness/Temper

Comments:_____

_____

Gilbert Neurology

Patient Registration

3507 S. Mercy Rd. Ste 101 Gilbert AZ 85297
7400 S Power Rd. Ste 120 Gilbert AZ 85297
Phone (480) 926-0644 Fax(480) 926-0645

Patient Name:_____ Gender___M___F **Date:**_____

Mailing Address:_____ S.S. #_____

City, State, Zip:_____ **Date of Birth:**_____

Home: (___)_____ **Cell:** (___)_____

E-mail address:_____

Physical Address (if different from mailing): _____ ____married ____single ____divorced

City, State, Zip: _____ ____ widowed ____ partnered

Preferred language: ___English ___Spanish ___Other_____ Race: ___American Indian ___Asian
___African American ___White

Ethnicity: ___Hispanic or Latino ____Not Hispanic or Latino ___Hispanic or Latino ___Other

Referring Physician:_____
(First and Last Name)

Phone: (_____)_____ Practice Name:_____

Primary Care Physician: _____
(First and Last Name)

Phone: (_____)_____ Practice Name:_____

Pharmacy:_____ Phone:(___)_____

Cross streets _____

Mail Order Pharmacy:_____ Phone:(___)_____

Primary Insurance:_____

ID #:_____ Group #:_____
(PLEASE STILL PROVIDE PHYSICAL COPY OF INSURANCE CARD)

Secondary Insurance:_____

ID #:_____ Group #:_____
(PLEASE STILL PROVIDE PHYSICAL COPY OF INSURANCE CARD)

Name of Primary Insured (if not self):_____ Date of Birth:_____

Relationship to Patient:_____ S.S.#:_____

Emergency Contact:_____ Relation to Patient: _____

Phone: (_____)_____

Do you have a Living Will? _____yes _____no Do you have a Health Care Power of Attorney? ____yes _____no
If yes, please provide a copy for our office

Signature:_____ **Date:**_____
Circle one: Patient / Parent / Guardian

Gilbert Neurology

480-926-0644 480-926-0645-fax

Patient Communication and Consent

Patient Name: _____Date of Birth: _____

There are occasions when Gilbert Neurology may have to call to discuss Confidential Protected Health Information. Please let us know how you would like us to get this information to you:

____ Ok to call my home/cell phone and leave a message on the answering machine

____ Ok to call my home but DO NOT leave a message

____ Do Not call my home phone but call this number ( ) _____

____ Do Not leave message with family member

Who may receive information regarding your Protected Health Information?
Check all that apply.

____ Spouse Name and date of birth: _____

____ Children Name and date of birth _____

Name and date of birth _____

Name and date of birth _____

____ Parents Names and date of birth: _____

____ Significant Other/Friend Name and date of birth: _____

_____

I have received a copy of the Notice of Privacy Practices from this provider and authorize the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to Gilbert Neurology.

I hereby authorize Gilbert Neurology to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical records including pharmacy records to Gilbert Neurology upon request.

Signature: _____Date: _____

Gilbert Neurology, P.L.L.C. Financial Policy

3507 S Mercy Rd., Suite 101 Gilbert, AZ 85297
7400 S. Power Rd. Suite 120 Gilbert, AZ 85297
Phone: (480) 926-0644 Fax: (480) 926-0645

Patient Name_____

*****PLEASE INITIAL ALL OF THE FOLLOWING*****

_____ **Unless 24-hour notice is given, I understand that there will be a $25 charge for broken appointments and a $50 charge for procedures and infusions.**

_____I understand that I am financially responsible for any copayments, deductibles, coinsurance and all charges which are not covered by my insurance. I understand that verification of coverage does not guarantee payment of benefits. My insurance company determines insurance benefit payments. I understand I will be responsible for that portion of all charges not covered by my insurance.

____I understand that I am responsible for all charges if it is determined that the insurance information I have provided is not correct.

____**Due to the large number of insurance plans and policies, it is the patient's responsibility to be aware of the services that are covered by your plan. Please call your insurance company for an explanation of your benefits.**

____**I understand that I am responsible for my co-pay at the time of my visit. We accept cash, all major credit cards, and personal checks.**

____I understand that there is a $25 charge for a Non-Sufficient Funds (NSF) check.

____I understand that there is a charge ranging from $25-$300 for all forms deemed necessary and filled out by the Physician OR Nurse Practitioner (e.g. Disability, FMLA, etc.) and I understand that I if I need an appointment with the Doctor or Nurse Practitioner to fill out these forms we will not be billing the insurance. The form fee must be paid at time of service or upon completion of the forms.

____I understand that Gilbert Neurology does not accept liens; worker's compensation, or MVA/auto claims and that I am responsible for any insurance claims denied as such. If my medical insurance denies or takes back any monies provided, I understand that I am responsible to pay all claims in full.

____If my account is not paid in full within 90 days, I understand that it will be considered delinquent. No additional appointments will be made for patients with delinquent accounts until they are brought current. Delinquent accounts will be turned over to a collection agency.

____I hereby authorize the release of information that may be necessary in the processing of any insurance claims.

____I hereby authorize my insurance company to make payment directly to: Gilbert Neurology, P.L.L.C.

____**I have read and I understand the above Financial Policy and I agree to abide by its terms. No changes to this policy by the patient will be acknowledged. Questions may be directed to the billing office.**

Signature of patient (or parent / guardian) _____

Print Name _____ **Date**_____

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Consent to Obtain External Prescription History

I, _____ , whose signature appears below, authorize Gilbert Neurology and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by your provider and staff.

My signature certifies that I read and understand the scope of this consent and that I authorize the access.

_____ _____
Print Patient Name DOB

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date