

# NEUROLOGY

## REGISTRATION FORM

<b>PATIENT INFORMATION</b>				
(Please Print)				
Last Name:		First Name:		Middle Initial:
Social Security Number:		<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (circle one): Single / Married / Divorced / Separated / Widowed	
Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Other Name:		Birth Date:	Age:	Sex:
Mailing Address:			City/State:	Zip:
Email Address:		Home Phone: (    )	Cell Phone: (    )	
Race:	Ethnicity:		Language:	
Employment Related: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Accident:	Auto Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Attorney:				
Occupation:		Employer:	Work Phone: (    )	
Pharmacy Name:		Phone: (    )	Location:	
Are you being referred by another Doctor? <input type="checkbox"/> No <input type="checkbox"/> Yes    Name:				
Would you like us to supply you with an Advance Directive (Living Will)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Would you like us to supply you with a Do Not Resuscitate Form (DNR)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>IN CASE OF EMERGENCY</b>				
Name of Local Friend or Relative:			Home Phone: (    )	
Relationship:			Cell Phone: (    )	
<b>METHOD OF PAYMENT</b>				
<input type="checkbox"/> Insurance	<input type="checkbox"/> Cash	<input type="checkbox"/> Check	<input type="checkbox"/> Credit Card	<input type="checkbox"/> Other

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

Please fill in the appropriate bubble for each question completely.

Allergy

Rash?	<input type="radio"/> Yes <input type="radio"/> No	Itchy Eyes?	<input type="radio"/> Yes <input type="radio"/> No
Runny Nose?	<input type="radio"/> Yes <input type="radio"/> No	Ear Fullness?	<input type="radio"/> Yes <input type="radio"/> No
Scratchy Throat?	<input type="radio"/> Yes <input type="radio"/> No	Sinus Congestion?	<input type="radio"/> Yes <input type="radio"/> No

Respiratory

Leg Pain?	<input type="radio"/> Yes <input type="radio"/> No	Chest Congestion?	<input type="radio"/> Yes <input type="radio"/> No
Shortness of Breath?	<input type="radio"/> Yes <input type="radio"/> No	Cough?	<input type="radio"/> Yes <input type="radio"/> No
Chest Pain?	<input type="radio"/> Yes <input type="radio"/> No		

Cardiology

Leg Pain?	<input type="radio"/> Yes <input type="radio"/> No	Chest Pain?	<input type="radio"/> Yes <input type="radio"/> No
Murmur?	<input type="radio"/> Yes <input type="radio"/> No	Palpitations?	<input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure?	<input type="radio"/> Yes <input type="radio"/> No	Leg Swelling?	<input type="radio"/> Yes <input type="radio"/> No
High Cholesterol?	<input type="radio"/> Yes <input type="radio"/> No	Shortness of Breath?	<input type="radio"/> Yes <input type="radio"/> No
Dizziness?	<input type="radio"/> Yes <input type="radio"/> No	Varicose Veins?	<input type="radio"/> Yes <input type="radio"/> No

Constitutional

Chills?	<input type="radio"/> Yes <input type="radio"/> No	Weakness?	<input type="radio"/> Yes <input type="radio"/> No
Weight Gain?	<input type="radio"/> Yes <input type="radio"/> No	Weight Loss?	<input type="radio"/> Yes <input type="radio"/> No
Loss of Appetite?	<input type="radio"/> Yes <input type="radio"/> No	Fatigue?	<input type="radio"/> Yes <input type="radio"/> No
Fever?	<input type="radio"/> Yes <input type="radio"/> No		

Dermatology

Hair Loss?	<input type="radio"/> Yes <input type="radio"/> No	Dry/Sensitive Skin?	<input type="radio"/> Yes <input type="radio"/> No
Itching?	<input type="radio"/> Yes <input type="radio"/> No	Hives?	<input type="radio"/> Yes <input type="radio"/> No
Rash?	<input type="radio"/> Yes <input type="radio"/> No	Acne?	<input type="radio"/> Yes <input type="radio"/> No
Mole?	<input type="radio"/> Yes <input type="radio"/> No	Skin Cancer?	<input type="radio"/> Yes <input type="radio"/> No
Lumps?	<input type="radio"/> Yes <input type="radio"/> No		

Endocrinology

Weight Gain?	<input type="radio"/> Yes <input type="radio"/> No	Sleep Disturbance?	<input type="radio"/> Yes <input type="radio"/> No
Fatigue?	<input type="radio"/> Yes <input type="radio"/> No	Cold Intolerance?	<input type="radio"/> Yes <input type="radio"/> No
Excessive Thirst?	<input type="radio"/> Yes <input type="radio"/> No	Heat Intolerance?	<input type="radio"/> Yes <input type="radio"/> No
Excessive Urination?	<input type="radio"/> Yes <input type="radio"/> No	Diabetes?	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss?	<input type="radio"/> Yes <input type="radio"/> No		

Ear/Nose/Throat

Ear Pain?	<input type="radio"/> Yes <input type="radio"/> No	Hearing Loss?	<input type="radio"/> Yes <input type="radio"/> No
Ear Discharge?	<input type="radio"/> Yes <input type="radio"/> No	Change in Voice?	<input type="radio"/> Yes <input type="radio"/> No
Trouble Swallowing?	<input type="radio"/> Yes <input type="radio"/> No	Sore Throat?	<input type="radio"/> Yes <input type="radio"/> No
Nasal Discharge?	<input type="radio"/> Yes <input type="radio"/> No	ringing in Ears?	<input type="radio"/> Yes <input type="radio"/> No
Cough?	<input type="radio"/> Yes <input type="radio"/> No	Sinus Pain?	<input type="radio"/> Yes <input type="radio"/> No
Nose Bleed?	<input type="radio"/> Yes <input type="radio"/> No		

Gastroenterology

Jaundice?	<input type="radio"/> Yes <input type="radio"/> No	Trouble Swallowing?	<input type="radio"/> Yes <input type="radio"/> No
Nausea?	<input type="radio"/> Yes <input type="radio"/> No	Diarrhea?	<input type="radio"/> Yes <input type="radio"/> No
Heartburn?	<input type="radio"/> Yes <input type="radio"/> No	Constipation?	<input type="radio"/> Yes <input type="radio"/> No
Vomiting?	<input type="radio"/> Yes <input type="radio"/> No	Blood in Stool?	<input type="radio"/> Yes <input type="radio"/> No
Abdominal Pain?	<input type="radio"/> Yes <input type="radio"/> No	Hemorrhoids?	<input type="radio"/> Yes <input type="radio"/> No

Hematology/Lymph

Swollen Glands?	<input type="radio"/> Yes <input type="radio"/> No	Varicose Veins?	<input type="radio"/> Yes <input type="radio"/> No
Fatigue?	<input type="radio"/> Yes <input type="radio"/> No	Easy Bruising/Bleeding?	<input type="radio"/> Yes <input type="radio"/> No

Musculoskeletal

Neck Pain?	<input type="radio"/> Yes <input type="radio"/> No	Joint Swelling?	<input type="radio"/> Yes <input type="radio"/> No
Back Pain?	<input type="radio"/> Yes <input type="radio"/> No	Leg Cramps?	<input type="radio"/> Yes <input type="radio"/> No
Joint Stiffness?	<input type="radio"/> Yes <input type="radio"/> No	Fracture?	<input type="radio"/> Yes <input type="radio"/> No
Joint Pain?	<input type="radio"/> Yes <input type="radio"/> No	Carpal Tunnel?	<input type="radio"/> Yes <input type="radio"/> No

Neurology

Loss of Consciousness?	<input type="radio"/> Yes <input type="radio"/> No	Seizures?	<input type="radio"/> Yes <input type="radio"/> No
Tremor?	<input type="radio"/> Yes <input type="radio"/> No	Insomnia?	<input type="radio"/> Yes <input type="radio"/> No
Head Injury?	<input type="radio"/> Yes <input type="radio"/> No	Memory Loss?	<input type="radio"/> Yes <input type="radio"/> No
Headache?	<input type="radio"/> Yes <input type="radio"/> No	Dizziness?	<input type="radio"/> Yes <input type="radio"/> No
Tingling/Numbness?	<input type="radio"/> Yes <input type="radio"/> No	Gait Abnormality?	<input type="radio"/> Yes <input type="radio"/> No

Ophthalmology

Eye Pain?	<input type="radio"/> Yes <input type="radio"/> No	Drainage from Eyes?	<input type="radio"/> Yes <input type="radio"/> No
Double Vision?	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision?	<input type="radio"/> Yes <input type="radio"/> No
Diminished Vision?	<input type="radio"/> Yes <input type="radio"/> No	Seasonal Eye Symptoms?	<input type="radio"/> Yes <input type="radio"/> No
Eye Irritation?	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision?	<input type="radio"/> Yes <input type="radio"/> No

Psychology

Confusion?	<input type="radio"/> Yes <input type="radio"/> No	Suicidal Ideas?	<input type="radio"/> Yes <input type="radio"/> No
Depression?	<input type="radio"/> Yes <input type="radio"/> No	Eating Disorder?	<input type="radio"/> Yes <input type="radio"/> No
High Stress Level?	<input type="radio"/> Yes <input type="radio"/> No	Mental/Physical Abuse?	<input type="radio"/> Yes <input type="radio"/> No
Sleep Disturbance?	<input type="radio"/> Yes <input type="radio"/> No	Anxiety?	<input type="radio"/> Yes <input type="radio"/> No

Urology

Difficulty Urinating?	<input type="radio"/> Yes <input type="radio"/> No	Voiding Dysfunction?	<input type="radio"/> Yes <input type="radio"/> No
Blood in Urine?	<input type="radio"/> Yes <input type="radio"/> No	Recurrent Infections?	<input type="radio"/> Yes <input type="radio"/> No
Frequent Urination?	<input type="radio"/> Yes <input type="radio"/> No	Bedwetting?	<input type="radio"/> Yes <input type="radio"/> No
Urinary Incontinence?	<input type="radio"/> Yes <input type="radio"/> No		

Social History

Smoking?	<input type="radio"/> Yes <input type="radio"/> No	Alcohol?	<input type="radio"/> Yes <input type="radio"/> No
Recreational Drug Use?	<input type="radio"/> Yes <input type="radio"/> No	Sexually Active?	<input type="radio"/> Yes <input type="radio"/> No
Exercise?	<input type="radio"/> Yes <input type="radio"/> No	Travel Outside the U.S.?	<input type="radio"/> Yes <input type="radio"/> No
Caffeine?	<input type="radio"/> Yes <input type="radio"/> No	Occupation?	_____

Marital Status?                       Married       Single       Divorced       Widowed

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

## Past Medical History

NONE

- |                                                     |                                               |                                         |
|-----------------------------------------------------|-----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> DVT/ Blood Clots     | <input type="checkbox"/> Osteoporosis   |
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Arthritis      |
| <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> TIA                  | <input type="checkbox"/> Neck Condition |
| <input type="checkbox"/> COPD/Emphysema             | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Back Condition |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Migraines/Headaches  | <input type="checkbox"/> GERD           |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Cancer (Type): _____ |                                         |
| <input type="checkbox"/> Other (Please List): _____ |                                               |                                         |

## Past Surgical History

## Allergies

## Current Medications

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

## Family History

**Father:**  Alive  Deceased Age \_\_\_ Medical Conditions: \_\_\_\_\_

**Mother:**  Alive  Deceased Age \_\_\_ Medical Conditions: \_\_\_\_\_

**Paternal Grand Father:**  Alive  Deceased Age \_\_\_ Medical Conditions: \_\_\_\_\_

**Paternal Grand Mother:**  Alive  Deceased Age \_\_\_ Medical Conditions: \_\_\_\_\_

**Maternal Grand Father:**  Alive  Deceased Age \_\_\_ Medical Conditions: \_\_\_\_\_

**Maternal Grand Mother:**  Alive  Deceased Age \_\_\_ Medical Conditions: \_\_\_\_\_

**Siblings:**  Alive  Deceased Age \_\_\_ Medical Conditions: \_\_\_\_\_

**Children:**  Alive  Deceased Age \_\_\_ Medical Conditions: \_\_\_\_\_

**AUTHORIZATION AND AGREEMENT FOR MEDICAL TREATMENT**

***THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGMENTS AND AGREEMENTS REGARDING THE MEDICAL TREATMENT TO BE PROVIDED TO THE PATIENT WHOSE NAME APPEARS ON THIS FORM HEREOF:***

**CONSENT TO TREATMENT:** I understand that medical treatment is necessary for the patient and that medical care; treatment and procedures will be performed by licensed physicians, and/or other employees of Paul Elliott, DO, PA (Jose Arbona, MD) and/or Lara Fix, DO, PA, herein after "PE/LF" during normal operating hours. I understand that medical treatment only is being provided. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results, which may be obtained.

**COMPLICATIONS:** I understand that it is my responsibility to PE/LF to immediately report any changes in my condition.

**SELECTION OF A PERSONAL PHYSICIAN:** I understand that if hospitalization or further treatment is required, PE/LF will attempt to contact the patient's personal physician to provide service. If the patient does not have a personal physician or the personal physician cannot be contacted, PE/LF may select any other qualified physician to provide this care.

**AGREEMENT TO PAY SERVICES:** For and in consideration of the care and treatment provided to the patient not covered by insurance, I promise to pay to PE/LF, all charges for services rendered to or on behalf of the patient not covered by insurance. In the event the account becomes delinquent and is turned over to a collection agency or an attorney, the patient shall be responsible for any and all additional costs, fees and/or charges incurred for such collection efforts by said agency and/or attorney.

**Co-Payment Responsibility:** If your insurance policy requires a co-payment, this will be required at the time of service.

**RELEASE OF MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS:**

I hereby authorize and direct payment to PE/LF for medical benefits, if any, otherwise payable to me under the terms of my insurance. Furthermore, I authorize PE/LF and give them power of attorney to endorse/sign my name on any and all checks, drafts or money orders for payment to PE/LF or to any Doctor who is employed by PE/LF for services rendered to me as a result of injury or illness for which I have treated by said office.

**CHECK APPROVAL:** The following information is required prior to accepting personal checks. This form need only be completed once and will be kept on file with your medical records. Please present your driver's license at the front desk. A minimum of \$25.00 service charge will be added to your account for any returned check payments in addition to any bank service charges incurred by PE/LF.

**NOTE:** All returned checks will be turned over to the state attorney for criminal prosecution. I have read and fully understand the above. The information I have provided is true to the best of my knowledge.

I acknowledge full financial responsibility for services rendered by Paul Elliott, DO, PA (Jose Arbona, MD) and/or Lara Fix, DO, PA or employees, and authorize transfer of all unpaid amounts to my Discover/Visa/Master Card/American Express, or any other credit card I may have used.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Paul Elliott, DO, PA (Jose Arbona, MD) and/or Lara Fix, DO, PA reserves the right to modify the privacy practices posted in the waiting room. I have received a copy of the Notice of Privacy Practices for Paul Elliott, DO, PA (Jose Arbona, MD) and/or Lara Fix, DO, PA .

**I HAVE READ THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS, AND FULLY UNDERSTAND THE SAME.**

**INDIVIDUAL PATIENT DISCLOSURE FORM**

**I hereby give my authorization to disclose my protected health information to (name of person such as daughter, husband, etc.)**

**I understand this authorization provides that:**

- **I have the right to access my protected health information to be used or disclosed.**
- **I may revoke this authorization at any time by contacting your office.**
- **This practice will not condition treatment on my providing authorization.**
- **I will receive a copy of this completed and signed authorization form.**

**MISSED APPOINTMENT AGREEMENT**

As a courtesy, our office will do our best to confirm your appointment the day before it is scheduled. If you do not show up at your scheduled appointment time without giving a 24 hour notice, your appointment will be considered a **NO-SHOW**. There will be a \$25.00 charge for a **NO-SHOW** appointment for a doctor visit and a \$50.00 charge for a **NO-SHOW** diagnostic study appointment. This is our policy and it is your responsibility as the patient to know when your appointment is. Please give us at least 24 hours notice if you are unable to keep your scheduled appointment. This policy is effective as of 01/01/2013. Thank you for your cooperation and understanding.

PATIENT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  

First	Middle	Last
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Mailing Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
\_\_\_\_\_

The undersigned hereby requests and authorizes the release of records from the following:

To: 

List Physician/Office and address or Hospital location
--------------------------------------------------------

Physician	Address	City/State	Zip Code

Telephone	Secured Fax	E-Mail Address

**Please check the box next to each type of records you would like to be disclosed** (Include visit dates on line provided)

- Most recent History and Physical or specific date(s): \_\_\_\_\_
- Most recent Discharge Summary or specific date(s): \_\_\_\_\_
- Most recent lab result or specific date(s): \_\_\_\_\_
- Pathology report, specific date(s): \_\_\_\_\_
- Radiology and other Diagnostic Reports/test results, specific date(s): \_\_\_\_\_
- Entire Record (All Labs, Diagnostic Reports, Operative Notes, Pathology Reports, Office Notes)

**Certain confidential information may be in your records. Please check below to specifically authorize disclosure of:**

- HIV/AIDS Test Results/Record Notations
- STD Records (Sexually Transmitted Diseases)
- Mental Health Treatment Records (excluding **Psychotherapy Notes**– separate authorization form required for release)
- Drug and Alcohol Treatment Records
- Genetic Testing

**Purpose(s) of Request:** \_\_\_\_\_

Pursuant to Florida Law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. A covered entity (that is, a source of medical information about you) may not condition, treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. I understand that I may revoke this authorization at any time, in writing, to the address listed below, **Medical Records Custodian, 931 SE Ocean Blvd. Suite A, Stuart, FL 34994**, provided that the information has not yet been released.

This authorization expires in six (6) months unless otherwise specified: \_\_\_\_\_

Patient or Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Explain and/or attach Legal Documentation
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