Neurology and Sleep Medicine Associates

(480) 967-6888 (phone); (480) 967-6887 (FAX)

Mesa Office
Augusta Ranch Professional Village
2919 South Ellsworth Road, Suite 135
Mesa, Arizona 85212

Tempe Office
Tempe St. Lukes Medical Office
1492 South Mill Avenue, Suite 214
Tempe, Arizona 85281

Patient Registration Form (Confidential)

Date: _____

Patient Name:_____ Responsible Party Name:_____

Mailing Address:_____ City, State, Zip:_____

Permanent Address:_____ City, State, Zip:_____

Home Phone:_____ Business Phone:_____ Cell Phone:_____

Email Address: _____ Pharmacy Number: _____

Sex: □ male □ female Birth Date (MM/DD/YYYY):_____ Age:_____

Marital status: □ married □ single

Patient's Social Security #:_____ Responsible Party Social Security #:_____

Relation to Patient: □ self □ spouse □ child □ other_____

Referring Doctor's Name and Number:_____

Primary Care Doctor's Name and Number:_____

Employer Name and Number:_____

Billing information: I prefer you to bill my claims to:

1. The name of primary insurance: _____ ID #_____
2. The name of secondary insurance: _____ ID# _____
3. Do you have Medicare? □ yes □ no If yes, your Medicare # _____

Is this visit injury related or from an accident? □ yes □ no
If injury or accident: □ auto accident □ job related injury, Date of Incident_____

Claim Number: _____ Third Party Information: _____

_____

Is there an attorney involved in your case? □ yes □ no If yes, Your Attorney Name and Number:
_____

_____

Chief Complaints:

What is the chief problem that brings you to the Clinic?

_____

_____

How long have you had the problem?_____

What do you think might be causing it?_____

Current Medical Problem and Illness:

Disease	Year Diagnosed			Disease	Year Diagnosed
1.				6.	
2.				7.	
3.				8.	
4.				9.	
5.				10.	

Have you ever had? (Please check all that apply)

__ cancer (type?_____) __ AIDS or HIV __ radiation therapy __ chemotherapy

__ stroke (what year?_____) __ seizures __ depression __ anxiety

__ congestive heart failure __ hypertension __ asthma __ COPD

__ diabetes (for _____years?) __ thyroid dz __ kidney stone __ blood clot

__ hepatitis (type?_____) __ stomach ulcer __ rheumatic fever __ polio

__ sexually transmitted dz __ shingles __ headache __ sinus problem

others: _____

Previous Surgeries:

Surgical Disease	Year of Surgery			Surgical Disease	Year of Surgery
1.				4.	
2.				5.	
3.				6.	

Medications: List all medications that you have been taking recently, including all vitamins and non-prescribed medications. Please bring all medications for your visit.

Name	Dose (mg)	Times per day	Name	Dose(mg)	Times per day
1._____			6._____		
2._____			7._____		
3._____			8._____		
4._____			9._____		
5._____			10_____		

Allergies: Reaction to medications or other substances. List all medications and substances.

Name of Medication	Type of Reaction
1._____	_____
2._____	_____
3._____	_____

Family History: List **major** medical problems in your family.

Disease	Who has it?			Disease	Who has it?
1.				4.	
2.				5.	
3.				6.	

Social History:

Primary occupation:_____

Tobacco: □ yes □ no Have you ever smoked? □ yes □ no
Type and amount:_____ Years:_____ If stopped, when?_____

Alcohol: □ yes □ no Have you ever drank alcohol? □ yes □ no
Type and amount:_____ Years:_____ When was last drink?_____

Recreational drugs: □ yes □ no Have you ever used recreational drugs? □ yes □ no
Type and amount:_____ Years:_____ When was last use?_____

Exercise: □ yes □ no If Yes, what type?_____ How often?_____

Authorization to Pay: I hereby authorize payment directly to the business office of this physician/clinic for any treatment and / or medical benefits, if any, otherwise payable to me for service. I understand that I am financially responsible for the charges not covered by my insurance.

_____ Signature (Patient or Guardian, if patient is minor)