PATIENT REGISTRATION

****FILL OUT COMPLETELY AND BRING YOUR INSURANCE CARDS TO YOUR APPOINTMENT****

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____

SOCIAL SECURITY #: _____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

LANGUAGE: _____ LANGUAGE COUNTRY: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _____ (what medical facility?)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCES? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE #: _____

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____ BUSINESS NAME: _____

BUSINESS PHONE: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY _____

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by __Huntington Headache and Neurology__ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practice for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners:

VIA MAIL	PLEASE INITIAL
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
☐ OK TO FAX TO	_____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

HUNTINGTON HEADACHE AND NEUROLOGY

HEALTH HISTORY FORM

DATE: _____

NAME: _____ DOB: _____ AGE: _____

OCCUPATION: _____

RIGHT _____ OR LEFT _____ HANDED?

WHO REFERRED YOU TO OUR NEUROLOGY CLINIC?

NAME: _____

ADDRESS: _____

PHONE # (____) _____ RELATION: _____

CHIEF COMPLAINT: (DESCRIBE THE REASON YOU ARE BEING SEEN. If you experienced an injury, please describe how it happened).

_____

_____

PAST MEDICAL HISTORY: (Describe any medical problems you have had in the past or currently have, and the year they were diagnosed).

_____

_____

PREVIOUS SURGERIES: (PLEASE LIST ALL SURGERIES YOU HAVE HAD IN THE PAST). List the date, type of surgery, hospital, and doctor's name.

_____

_____

ALLERGIES:

Are you allergic to any medications? YES _____ NO _____

If yes, please name: _____

FAMILY HISTORY:

Have any of your blood relatives had any problems during surgery related to anesthesia?

_____

SOCIAL HISTORY:

Do you smoke: YES _____ NO _____ If yes, how much? _____

If no, have you in the past? YES _____ NO _____ How much? _____

Do you drink alcoholic beverages? YES _____ NO _____

If yes, how often? _____

Do you use "recreational" drugs? YES _____ NO _____

HAVE YOU HAD	DATE PERFERMED	LOCATION PERFORMED
X-RAYS	_____	_____
MRI	_____	_____
CT SCAN	_____	_____
EMG	_____	_____
MYELOGRAM	_____	_____

HUNTINGTON HEADACHE AND NEUROLOGY

Fits, Spells, and Loss of Consciousness Screening Questionnaire

Please answer the following questions by marking the most appropriate response to each question with and **X**.

1. Did anyone ever tell you that you had a seizure or convulsion caused by a high fever when you were a child?
   _____ YES _____ NO _____ POSSIBLE _____ DON'T KNOW

2. Have you ever had, or has anyone ever told you that you had, a seizure disorder or epilepsy?
   _____ YES _____ NO _____ POSSIBLE _____ DON'T KNOW

   If you answered YES to question 2 above, **STOP HERE**. Otherwise, please continue.

3. Have you ever had, or has anyone ever told you that you had, any of the following:
   a. A seizure, convulsion, fit or spell under any circumstances?
      _____ YES _____ NO _____ POSSIBLE _____ DON'T KNOW

   b. Uncontrolled movements of part or all of your body such as twitching, jerking, shaking or going limp?
      _____ YES _____ NO _____ POSSIBLE _____ DON'T KNOW

   c. An unexplained change in your mental state or level of awareness; or an episode of "spacing out" that you could not control?
      _____ YES _____ NO _____ POSSIBLE _____ DON'T KNOW

   d. Did anyone ever tell you that when you were a small child, you would daydream or stare into space more than other children?
      _____ YES _____ NO _____ POSSIBLE _____ DON'T KNOW

   e. Have you ever noticed any unusual body movements or feelings when exposed to strobe lights, video games, flickering lights, or sun glare?
      _____ YES _____ NO _____ POSSIBLE _____ DON'T KNOW

   f. Shortly after waking up, either in the morning or after a nap, have you ever noticed uncontrollable jerking or clumsiness, such as dropping things or things suddenly "flying" from your hands?
      _____ YES _____ NO _____ POSSIBLE _____ DON'T KNOW

   g. Have you ever had any other types of repeated unusual spells?
      _____ YES _____ NO _____ POSSIBLE _____ DON'T KNOW

_____ _____ _____

Patient Name Signature Date

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING AND DATES:

☐ Heart trouble	___/___/___	☐ Thyroid disease	___/___/___	☐ Blood clots	___/___/___
☐ High blood pressure	___/___/___	☐ Migraine	___/___/___	☐ Elevated cholesterol	___/___/___
☐ Asthma	___/___/___	☐ Hepatitis	___/___/___	☐ Ulcer	___/___/___
☐ Emphysema	___/___/___	☐ Liver disease	___/___/___	☐ Colitis	___/___/___
☐ TB	___/___/___	☐ Gall stones	___/___/___	☐ Bone disease	___/___/___
☐ Pneumonia	___/___/___	☐ Kidney disease	___/___/___	☐ Back pain	___/___/___
☐ Pleurisy	___/___/___	☐ Kidney stones	___/___/___	☐ Neck pain	___/___/___
☐ Other lung disease	___/___/___	☐ Gout	___/___/___	☐ Eye problems	___/___/___
☐ Diabetes	___/___/___	☐ Arthritis	___/___/___	☐ Venereal disease	___/___/___
☐ Blood transfusion	___/___/___	☐ Mental illness	___/___/___		
☐ Cancer	___/___/___	☐ Tropical disease	___/___/___		

SYSTEM REVIEW GENERAL

☐ Recent weight gain/ amount
☐ Recent weight loss/ amount
☐ Fatigue
☐ Weakness
☐ Fever

NERVOUS SYSTEMS

☐ Headaches
☐ Dizziness
☐ Fainting
☐ Muscle spasms
☐ Loss of consciousness
☐ Sensitivity or pain of hands
☐ Face numbness or tingling
☐ Muscle weakness
☐ Muscle tenderness
☐ Walking difficulty

EARS

☐ Ringing in ears
☐ Loss of hearing

EYES

☐ Pain
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness
☐ Feels like something in the eye
☐ Redness

MOUTH

☐ Sore tongue
☐ Bleeding gums
☐ Sore in mouth
☐ Loss of taste
☐ Dryness

THROAT

☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty swallowing

NECK

☐ Swollen glands
☐ Tender glands

HEART AND LUNGS

☐ Pain in chest
☐ Irregular heartbeat
☐ Sudden changes in heartbeat
☐ Shortness of breath
☐ Wheezing
☐ Night sweats
☐ Swollen legs or feet
☐ High blood pressure
☐ Heart murmurs
☐ Difficulty in breathing at night
☐ Coughing of blood
☐ Cough

STOMACH & INTESTINES

☐ Nausea
☐ Persistent diarrhea
☐ Vomiting of blood or coffee ground material
☐ Yellow jaundice
☐ Increasing constipation
☐ Stomach pain relieved by food or milk
☐ Blood in stools
☐ Black stools
☐ Heartburn

KIDNEY/URINE/BLADDER

☐ Difficulty urination
☐ Pain or burning on urination
☐ Blood in urine
☐ Cloudy "smoky" urine
☐ Pus in urine
☐ Discharge from penis/vagina
☐ Frequent urination getting up at night to pass urine
☐ Vaginal dryness
☐ Rash/ulcers
☐ Sexual difficulties
☐ Prostate trouble

PSYCHOLOGY

☐ Sad/depressed
☐ Happy/anxious
☐ Repetitive behavior/habits

ENDOCRINE

☐ Excessive thirst/hunger
☐ Nipple discharge

SKIN

☐ Easy bruising/amount
☐ Redness
☐ Rash
☐ Hives
☐ Sun sensitive
☐ Tightness
☐ Hair loss
☐ Nodules/bumps
☐ Color changes of hand or feet from the cold

JOINTS/BONE

☐ Morning stiffness lasting how long?
_____ hrs _____min
☐ Joint pain
☐ Joint swelling

BLOOD

☐ Anemia
☐ Bleeding tendency

NOSE

☐ Nosebleeds
☐ Loss of smell
☐ Dryness

WEIGHT

☐ Has your weight increased, decreased or remained the same in the past 2 years?
Yes No
If no, _____

I have reviewed and confirmed the information listed above on this page.

Physician's Name _____ Signature _____ Date _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	AGE:	HEALTH (DESCRIBE ANY MAJOR ILLNESS)	AGE:	CAUSE:
MOTHER:	_____	_____	_____	_____
		_____		_____
FATHER:	_____	_____	_____	_____
		_____		_____
SISTERS:	_____	_____	_____	_____
		_____		_____
BROTHERS:	_____	_____	_____	_____
		_____		_____
CHILDREN:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

HUNTINGTON HEADACHE AND NEUROLOGY

Medical Chart Update

Please list all medications you are currently taking even those prescribed by other doctors.

Date: _____ Date of Birth: _____

Patient's Name: _____

	Medication	**Prescribed by ANY doctor**	**Mg (strength)**	**Dose How many times a day**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Pharmacy Name: _____

Address: _____ City: _____

Phone #: _____

HUNTINGTON
HEADACHE AND NEUROLOGY

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http://huntingtonheadache.com

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Huntington Headache and Neurology. When you schedule an appointment with Huntington Headache and Neurology, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective July 1, 2021, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show. A no-show fee of **$25.00 will be charged for medical appointments** and **$50.00 for procedure appointments** (EEG, EMG/NCS, Injections, etc.)
- Any established patient who fails to show or cancels/reschedules a medical appointment with no 24 hour notice a **second** time will be charged a **$50.00 fee for medical appointments** and a **$100.00 fee for procedure appointments** (EEG, EMG/NCS, Injections, etc.).
- If a **third** No Show or cancellation/reschedule within 24 hour notice should occur, the patient may be **discharged** from Huntington Headache and Neurology.
- Any new patient who fails to show for their initial visit may not be rescheduled.
- The fee is charged to the patient, not the insurance company, and **must be paid prior to the patient being rescheduled.**
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please notify our office and we will consider exceptions on a case-by-case basis. You may contact Huntington Headache and Neurology by telephone, email, or through our website.

CENTERS FOR MEDICARE AND MEDICAID OPEN PAYMENTS DATABASE

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

I have been provided instructions on accessing the Open Payments database. Additionally, I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

HUNTINGTON
HEADACHE AND NEUROLOGY

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ZERO TOLERANCE HARASSMENT AND ABUSE POLICY

Huntington Headache and Neurology strives to create and maintain a patient care environment in which people are treated with dignity, decency and respect. The care provided here should be characterized by mutual trust and the absence of intimidation, oppression and exploitation. Huntington Headache and Neurology will not tolerate discrimination or harassment of any kind, including physical or verbal abuse. Through enforcement of this policy, Huntington Headache and Neurology seeks to prevent behavior that violates this policy.

All patients and caregivers are covered by and are expected to comply with this policy. Employees of Huntington Headache and Neurology will take appropriate measures to ensure that prohibited conduct does not occur. Action will be taken against any patient or caregiver who violates this policy and violations of this policy may result in the termination of the patient-physician, patient-nurse practitioner, or patient-office relationship.

Huntington Headache and Neurology prohibits harassment of any kind, including sexual harassment, and will take appropriate and immediate action in response to complaints or knowledge of violations of this policy. For purposes of this policy, harassment is any verbal or physical conduct designed to threaten, intimidate or coerce an employee or any person working for or on behalf of Huntington Headache and Neurology.

The following examples of harassment are intended to be guidelines and are not exclusive when determining whether there has been a violation of this policy:

- Verbal harassment includes comments that are offensive or unwelcome regarding a person's national origin, race, color, religion, age, sex, sexual orientation, pregnancy, appearance, disability, gender identity or expression, marital status or other protected status, including epithets, slurs and negative stereotyping.
- Nonverbal harassment includes distribution, display or discussion of any written or graphic material that ridicules, denigrates, insults, belittles or shows hostility, aversion or disrespect toward an individual or group because of national origin, race, color, religion, age, gender, sexual orientation, pregnancy, appearance, disability, sexual identity, marital status or other protected status.

By signing below, you acknowledge that you – the patient – are responsible for your actions and the actions of those that assist you. Furthermore, all interactions with Huntington Headache and Neurology are subject to this policy including, but not limited to, in-person appointments, in-person staff interactions, telephone calls, text messages, emails, and communication through the patient portal.

_____ _____

Signature Date

_____

Patient Name