# PATIENT REGISTRATION

NAME_____ SEX: M / F

DOB_____-_____-_____ SS #_____-_____-_____ MARITAL STATUS: S M W SEP D

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE #_____ CELL PHONE #_____ WORK PHONE #_____

E-MAIL_____ PREFERRED CONTACT METHOD HOME___ CELL___ WK ___ E-MAIL___

EMERGENCY CONTACT_____ RELATIONSHIP_____ PHONE_____

SPOUSE NAME_____ REFERRED BY_____

PHARMACY NAME_____ PHONE #_____

PATIENT EMPLOYER INFORMATION PCP_____

EMPLOYER NAME_____ PHONE #_____ EXT_____

ADDRESS_____ CITY_____

STATE_____ ZIP_____ OCCUPATION_____

INSURED PERSON (IF NOT PATIENT)

NAME_____ PHONE #_____ RELATIONSHIP_____

ADDRESS_____ CITY/STATE_____

INSURANCE

MEDICAID #_____ MEDICARE #_____

PRIMARY INSURANCE NAME_____

ID #_____ GROUP #_____

SECONDARY INSURANCE NAME_____

ID #_____ GROUP #_____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I authorize Dr._____(Tarrant Neurology Consultants PA) to apply for benefits on my behalf for services rendered by him or her. I request that payment be made directly to him/her or Tarrant Neurology Consultants PA. This authorization may be revoked by me at any time in writing.

SIGNATURE_____ DATE_____

NAME _____ CHIEF COMPLAINT _____

HISTORY OF PRESENT ILLNESS

CURRENT MEDICATIONS

1 _____ _____mg HOW OFTEN TAKEN _____
2 _____ _____mg HOW OFTEN TAKEN _____
3 _____ _____mg HOW OFTEN TAKEN _____
4 _____ _____mg HOW OFTEN TAKEN _____
5 _____ _____mg HOW OFTEN TAKEN _____
6 _____ _____mg HOW OFTEN TAKEN _____
7 _____ _____mg HOW OFTEN TAKEN _____
8 _____ _____mg HOW OFTEN TAKEN _____
9 _____ _____mg HOW OFTEN TAKEN _____
10 _____ _____mg HOW OFTEN TAKEN _____
11 _____ _____mg HOW OFTEN TAKEN _____
12 _____ _____mg HOW OFTEN TAKEN _____

ALLERGIES — TYPE OF REACTION

1 _____ _____
2 _____ _____
3 _____ _____
4 _____ _____

SOCIAL HISTORY

DO YOU DRINK ALCOHOL YES/NO DRINKS # _____ PER _____

DO YOU SMOKE YES/NO PACKS PER DAY _____

HAVE YOU EVER SMOKED YES/NO HOW LONG _____ STOPPED _____

DO YOU USE ANY RECREATIONAL DRUGS YES/NO

HAVE YOUR EVER USED RECREATIONAL DRUGS YES/NO STOPPED DATE _____

RECREATIONAL DRUGS YOU USE NOW OR IN PAST (please list) _____

NAME _____

MEDICAL HISTORY

Y/N HEADACHE/MIGRAINE
Y/N HEADACHE/TENSION
Y/N SEIZURES
Y/N CEREBRO VASCULAR
Y/N NEUROMUSCULAR
Y/N HEAD INJURY
Y/N SPINAL CORD INJURY
Y/N CERVICAL SPINE DISEASE
Y/N LUMBAR SPINE DISEASE
Y/N PERIPHERAL NERVE DIS
Y/N CNS MALIGNANCY
Y/N DEPRESSION
Y/N CORONARY ARTERY DIS
Y/N MI (HEART ATTACK)
Y/N CONGESTIVE HEART FAILURE
Y/N KIDNEY DISEASE
Y/N ARTHRITIS
Y/N TUBERCULOSIS
Y/N MUMPS
Y/N POLIO

Y/N MURMUR
Y/N HYPERTENSION
Y/N COPD
Y/N PNEUMONIA
Y/N ASTHMA
Y/N ULCER
Y/N POLYPS
Y/N BLEEDING DISORDER
Y/N ANEMIA
Y/N DIABETES
Y/N PERIPHERAL VASCULAR
Y/N THYROID DISEASE
Y/N MENSTRUAL/SEXUAL DYSFUNCTION
Y/N ARRHYTHMIAS
Y/N LIVER DISEASE
Y/N VENEREAL DISEASE
Y/N CANCER (TYPE)_____
Y/N HIV
Y/N MEASLES
Y/N RHEUMATIC FEVER

PRIOR SURGERIES / HOSPITALIZATIONS

REASON _____ DATE _____
REASON _____ DATE _____
REASON _____ DATE _____
REASON _____ DATE _____
REASON _____ DATE _____
REASON _____ DATE _____
REASON _____ DATE _____

ARE YOU PREGNANT NOW? YES / NO DUE DATE _____

THE FOLLOWING IS REQUESTED BY THE HEALTHCARE REFORM BILL PASSED BY CONGRESS AND WILL IN NO WAY IMPACT YOUR CARE HERE.

RACE: ASIAN
NATIVE HAWAIIAN
BLACK OR AFRICAN AMERICAN
WHITE
HISPANIC
OTHER
REFUSE TO REPORT

ETHNICITY: HISPANIC OR LATIN
NOT HISPANIC OR LATIN
REFUSED TO REPORT

LANGUAGE PREFERENCE:

_____