Phoenix Neurology
& Sleep Medicine

Phone: (623) 535-0050 Fax: (623) 535-9520

Patient Information

Date: _____

Name: _____ SSN_____
(Last) (First) (MI)

Address_____

City_____State_____ Zip Code_____

Home #_____Cell #_____ Work_____

Sex __Male Age_____ DOB_____ ___ Married ____Single ___Divorced

__Female Height: _____ Weight: _____ ___Widowed ___Other

Email Address _____

Employed? ___No ____ Yes Employer _____

Emergency Contact _____ Phone #_____

Referring Physician _____Phone #_____

Primary Care Doctor _____Phone #_____

Primary Insurance

Insurance Name: _____ Insured's Name _____

Insured's DOB _____ Insured's SSN_____

Relationship to Insured_____ Insurance Phone #_____

Policy or ID # _____Group #_____

Secondary Insurance

Insurance Name: _____ Insured's Name _____

Insured's DOB _____ Insured's SSN_____

Relationship to Insured_____ Insurance Phone #_____

Policy or ID # _____Group #_____

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Assignment and Release

I certify that I, and/or my dependents, have insurance and assign directly to Phoenix Neurology and Sleep Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Phoenix Neurology and Sleep Medicine may use my healthcare information and may disclose such information to the above named insurance company/s and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

If your account is sent to collections the patient is responsible for any and all fees accumulated.

Advanced Directive

Do you have an Advanced Directive in place?

____ Yes (Please provided a signed copy for your patient chart)

____ No

____ DNR (Do Not Resuscitate)

____ Living Will / Medical Power of Attorney

_____ _____

(Signature of the Patient/Parent/Guardian) (Date)

_____ _____

(Signature of the Patient/Parent/Guardian) (Date)

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Front Office and Appointment Guidelines

Pt Account#_____

- All co-payments and account balances are due at the time services are rendered, unless other arrangements have been made. We accept cash, check, Visa, MasterCard, American Express and Discover.
- Inform the front office receptionist of any change in demographics or insurance. Failure to do so may lead to an account balance.
- As a courtesy, PNSM will verify insurance is active prior to appointment. It is the responsibility of the insured member to ensure services are covered and in network.
- If you have an insurance plan that requires a paper referral or authorization number, it is your responsibility to make sure the referral has been completed by your primary care physician and is in our office for your scheduled appointment time. If we do not have a referral or authorization your appointment can be rescheduled. As a courtesy we do request a Continuation of Care Referral once expired but does not guarantee referring provider or PCP has sent one to us.
- Give a 24-hour or more notice when cancelling or rescheduling an appointment. There will be a fee accessed as follows:
    - **$50 fee for 24-hour cancellation and/or reschedule for appointments**
    - **$100 fee for No Show and/or same day cancellation for appointments**
    - **$150 fee for No Show and/or same day cancellation for procedure appointments (EEG/VNG/EMG/Botox/OCC)**
    - **$250 fee for No Show and/or same day cancellation for Sleep Test or EEG Ambulatory test appointments**
- If you are late for your appointment the doctor will be unable to see you.
- **There is a $35 fee for ALL NSF Returned Checks.**
- Please allow 24 to 48 hours for your prescription to be filled. PRESCRIPTIONS WILL NOT BE REFILLED OVER THE WEEKEND. The Physicians do not prescribe narcotics.
- Please allow 14 business days for your tests or procedures to be scheduled (e.g. MRIs, CTs, Physical Therapy, etc.). Either our office or the contracted facility will contact you to schedule the appointment.
- All documents that need to be reviewed and signed by a physician, such as FMLA and Disability forms require a **charge of $100** that must be paid prior to forms being completed. Completion of forms is up to each physician's discretion.
- We have a Zero Tolerance Policy for abusive behavior or language toward staff, providers, or any other patients. If we deem your or that of a relative/ acquaintances' behavior is unacceptable, we retain the right to cancel any and all appointments, and discharge you from our office. You will be referred back to your referring provider or PCP for redirection to another facility.

_____ _____

Patient Signature Date

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Patient Habits

1. Do you smoke? Yes No
   If yes, how much? _____
2. Do you exercise? Yes No
   If yes, how often? _____
3. Do you drink caffeinated beverages? Yes No
   How much per day? _____
4. Do you drink alcoholic beverages? Yes No
   How much per day? _____

Epworth Scale (Day Time Sleepiness)

Please CIRCLE the following questions based on this scale:

0 – Would never fall asleep

1 – Slight chance of dozing

2 – Moderate chance of dozing

3 – High chance of dozing

		Chance of Dozing			
1.	Sitting and reading	0	1	2	3
2.	Watching TV	0	1	2	3
3.	Sitting inactive in a public place	0	1	2	3
4.	As passenger in a car	0	1	2	3
5.	Lying down to rest in the afternoon	0	1	2	3
6.	Sitting and talking to someone	0	1	2	3
7.	Sitting quietly after lunch	0	1	2	3
8.	In a car while stopped in traffic	0	1	2	3

Total score:_____

Patient Name:_____ DOB:_____
(Please Print)

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Chief Complaint: Please explain why you have come here, including problems, date of onset, sudden or gradual onset, frequency, duration, nature and factors which bring on, worsen or improve this complaint. Please describe intermittent problems/spells as best as you can:

_____

_____

Past Medical History (Please mark all problem referring to the following functions.)
General Problems:

___ Energy ___ Weight Loss ___Fever ___Sweats ___Chills ___Fatigue ___Stamina ___Appetite

Neurological Problems:

___Headache/Migraine ___Blurred Vision ___Double Vision ___Hearing Loss ___Ringing in Ears
___Speech(slurred/loss)___Swallowing,Chewing ___Head Trauma ___Concussion ___Blackouts
___Seizures ___Dizziness ___Vertigo(spinning) ___Incontinence ___Weakness ___Coordination
___Gait ___Balance ___Involuntary Movements ___Insomnia ___Obstructive Sleep Apnea
___Restless Legs ___Stroke ___Confusion ___Memory Loss ___Neck Pain ___Low Back Pain
___Numbness/Tingling ___TIA Other_____

Medical Problems:

___Diabetes ___High Blood Pressure ___TB ___Heart Disease ___Heart Attack ___Asthma
___COPD ___Breathing Problems ___Thyroid ___Bleeding ___Clotting ___Anemia ___Colitis
___Irritable Bowel ___Fibromyalgia ___Lupus ___Rheumatoid Arthritis __Kidney Disease
___Lyme Disease ___Cancer ___Sleep ___Snoring ___Frequent Awakening
___Difficulty Falling Asleep Other_____

Review of Systems

Family History

___ Alzheimer's___ Stroke/Heart Attack ___ Epilepsy ___ Migraines/Headaches ___Neuropathy

Other: _____

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Social History

Smoking: Y/N PPD:_____
Former Smoker:

Alcohol: Y/N Drinks per Day:_____
Never Drink

Quit:
1-3 months
3-6 months
6-12 months
Years: _____

Current:
Everyday
Some Daily
Light/Moderate/Heavy

Caffeine: Y/N Amount: _____

Illicit Drugs: Y/N Name:_____

Past Surgical History (Please list all surgeries you have had.)

Current Medications and Dosages

Drug Allergies (Please list allergies to any medications and the reaction you have.)

What pharmacy should we list in our system where all your prescriptions will go to? (Please list name, address and phone number. If you do not have this information please list the major cross streets.)

_____ _____
(Pharmacy Name) (Cross Streets)

_____ _____
(Pharmacy Address) (Phone #)

Please CIRCLE your referred Radiology Clinic:

AZ Diagnostic Radiology Banner Imaging Evernorth Caregroup Imaging
SimonMed Imaging SMIL Imaging Sun Radiology Other:_____

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Patient Additional Information Needed

Please note we are required by the government to ask these questions for demographic purposes

Patient Name:_____ DOB: _____

Date: _____ Account #: _____

Please choose a Race:

___ Asian
___ American Indian / Alaska Native
___ Black / African American
___ Native Hawaiian / Other Pacific Islander
___ White
___ Declined

Please choose an Ethnicity:

___ Hispanic / Latino
___ Non-Hispanic / Latino
___ Declined

What languages do you speak?

How did you hear about this office:

___ My Insurance
___ IMS Marathon
___ Friend / Family Member
___ Quest Dex / Yellow Pages
___ Online Search
___ Other, Please Specify: _____

*THIS INFORMATION IS REQUIRED FOR STATISTICAL ANALYSIS. FROM THE AGENCIES OF EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT AND BUDGET, OFFICE OF INFORMATION AND REGULATROY AFFAIRS, DUE TO REVISIONS TO THE STANDARDS FOR THE CLASSIFICATION OF FEDERAL DATA ON RACE AND ETHNICITY (10/30/1997). THE REVISED STANDARDS WILL HAVE 5 MINIMUM CATEGORIES FOR DATA ON RACE (AMERICAN INDIAN OR ALASKA NATIVE, ASIAN, BLACK OR AFRICAN AMERICAN, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, AND WHITE) AND 2 CATEGORIES FOR DATA ON ETHNICITY (HISPANIC, NOT HISPANIC). OMB IS ANNOUNCING ITS DECISION CONCERNING THE REVISION OF STATISTICAL POLICY DIRECTIVE NO. 15, RACE AND ETHNIC STANDARDS OF FEDERAL STATISTICS AND ADMINSTRATIVE REPORTING.

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Release of Information

NAME:_____ DOB:_____
I hereby authorization PNSM to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: _____Relationship: _____ Phone #: _____

Name: _____Relationship: _____ Phone #: _____

Name: _____Relationship: _____ Phone #: _____

I authorize PNSM to contact me at:

Home #: _____ Work #:_____

May we leave a message on machine? ___ Yes ___ No

Cell #: _____ Alt #: _____

Signature below acknowledges you have read and understand the Privacy Notice and Patient Rights.

Patient Signature: _____ Date: _____

**********FOR OFFICE USE ONLY**********

Pt Account# _____ Initials _____ Date:_____

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Where Patients & Their Providers are Family

Phone: 623-535-0050 Fax: 623-535-9520

Goodyear
2940 N. Litchfield Road Goodyear, AZ 85395

Phoenix
300 E. Osborn Road Ste. 200 Phoenix, AZ 85012

Glendale
20100 N 51st Ave Ste. F640, Glendale, AZ 85308

Authorization to Release / Receive Medical Records

Patient Name _____ DOB: _____
Address_____ SSN: _____
_____
(City) (State) (Zip Code)

I hereby authorize Phoenix Neurology & Sleep PLLC to receive and/or release medical record information concerning the above named patient to:

Requesting Records From:
Name: _____
Phone Number: _____
Fax Number: _____
Address_____
_____
(City) (State) (Zip Code)

Releasing Records To:
Name: **Phoenix Neurology and Sleep Medicine**
Phone Number: **(623) 535-0050**
Fax Number: **(623) 535-9520**
Address **2940 N Litchfield Rd.**
Goodyear, AZ. 85395
(City) (State) (Zip Code)

☐ Copy of all medical records of the last two years of treatment received
☐ Copy of medical records covering dates from _____ to _____
☐ Copy of _____ results.

_____ _____
Patient's Signature Date

**********FOR OFFICE USE ONLY**********

☐ Printed Records on _____. Initials _____

☐ Given to _____ on _____. Initials _____

☐ Faxed on _____. Initials _____