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 paid by insurance or not. 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 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. The insured member is responsible for ensuring services are covered and in network.
- If you have an insurance plan that requires a paper referral or authorization number, you must ensure the referral is 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 (about 4 days) 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 unacceptable, we retain the right to cancel all appointments and discharge you from our office. You will be referred to your referring provider or PCP for redirection to another facility.

____ ______________________

Patient Signature Date

Phoenix Neurology & Sleep Medicine

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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 problems 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: _______________ Alcohol: Y/N Drinks per Day: ___________
Former Smoker: ______ 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 your 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 preferred 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
___ 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.

Phoenix Neurology & Sleep Medicine

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Release of Information/HIPPA

NAME: ____ DOB: _________________________

I hereby authorize PNSM to release or discuss 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 #: ____

Email address: ____

Contacting you. By signing this, you agree that we, our representative(s) or agent(s) may contact you. You agree that we may contact you using any contact information you have provided to us, from which you called us, or which we obtained and through which we believe we can reach you. You agree we may use any means to contact you. This may include calls made to your cellular telephone using an automatic telephone dialing system, artificial or prerecorded voice messages, text messages, mail, email, and calls to your phone or Voice over Internet Protocol (VoIP) service, or any other data or voice transmission technology. You agree to promptly notify us if you change any contact information you provide to us. You are responsible for any service charges because of us contacting you

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: ___________________

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

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 _____