

Foothills Neurology, P.C.

New Patient Registration

4530 East Muirwood Drive Suite 111, Phoenix, AZ 85048

Tel: (480)961-2365 Fax: (480)961-2381

Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Gender: M F

Home Phone: _____

Home phone is the same as cell phone

Mobile Phone: _____

None

Can we send you Text reminders? Y N

Work Phone: _____

Email: _____ No Email

What is your preferred way for us to contact you?

- | | |
|---|--|
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Ok to leave message |
| <input type="checkbox"/> Work Phone | <input type="checkbox"/> Ok to leave message |
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Ok to leave message |
| <input type="checkbox"/> Mail | |
| <input type="checkbox"/> Patient Portal On-Line | |

The U.S. Government would like the following information:

Marital Status: _____	Single	Married	Divorced	Widowed	Other	
Primary Language: _____						<input type="checkbox"/> Decline
Race: _____						<input type="checkbox"/> Decline
Ethnicity: _____						<input type="checkbox"/> Decline

Which Pharmacy would you like us to send your prescriptions to?

Pharmacy Cross Streets or Address or Phone Number

Which Laboratory would you like to go to if we send you for blood work?

Lab Cross Streets or Address or Phone Number

Family Doctor: _____ Which Office? _____

Referring Doctor: _____ Which Office? _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone: _____

Primary Insurance: _____ ID #: _____

Secondary Insurance: _____

Please bring your insurance card for us to copy

If the patient is not the primary policy holder...

Name of Primary: _____ DOB: _____ Gender: M F

The Patient is the primary policy holder's: Spouse Child Other

Patient Signature _____ Date _____

I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges, which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. Your insurance company determines insurance benefit payments. I understand I will be responsible for the portion not covered by my insurance.

I understand that Foothills Neurology *does not* accept liens, worker's compensation or MVA/auto claims and I am responsible for any insurance claims denied for such. If my medical insurance denies or takes back any monies provided, I understand I am responsible to pay all claims in full in a timely manner.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days of the billing date. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Patients are responsible for making sure that Dr. Stuart Hetrick is *in network* with your insurance provider. We verify insurance eligibility, *but we do not verify* that we are in each individual network.

Due to the large amount of insurance plans and policies, it is the patient's responsibility to be aware of the services that are covered by your plan. Please call your insurance company for an explanation of your benefits.

This is what you need to know:

- **You have to pay for services that your insurance company says are your responsibility.**
- **If your insurance is not active on the day of your appointment, you will have to pay the whole bill.**
- **Your co-pay must be paid before each visit.**
- **We will charge you \$50 if you miss your appointment unless 24-hour notice is given.**
- **There is a \$25 charge for a Non-Sufficient Funds (NSF) check.**

I hereby authorize the release of information that may be necessary in the processing of any insurance claims.

I hereby authorize my insurance company to make payment directly to: Foothills Neurology, P.C.

Signature of patient (or parent/guardian) _____

Print Name _____

Date _____

Foothills Neurology, P.C.

Privacy Notice

4530 East Muirwood Drive Suite 111, Phoenix, AZ 85048

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I have received the HIPAA Privacy Notice and HIPAA Omnibus Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records.

I hereby authorize Foothills Neurology to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical records including pharmacy records to Foothills Neurology upon request.

FAXES: When expedient, I authorize the transmittal of my records by FAX to doctors, pharmacies, insurance companies, or upon my request. I understand that transmission by FAX, by its very nature, is not confidential.

Patient Name

Date of Birth

Patient Signature

Date

PERSONAL REPRESENTATIVES (family members, attorneys, etc): I hereby authorize Foothills Neurology and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

Name

Relationship to Patient

Name

Relationship to Patient

MESSAGES:

Y N It is ok to leave a message on my home voice mail #: _____

Y N It is ok to leave a message on my work voice mail #: _____

CANCELLATION POLICY

At Foothills Neurology, our goal is to provide quality care in a timely manner. We have implemented an Appointment/Cancellation Policy which enables us to better utilize available appointments for our patients in need of care.

A “no show” is someone who missed an appointment without canceling it by 12:00 p.m. (1) one working day in advance. No-shows inconvenience those individuals who need access to neurological care in a timely manner. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to a provider.

Without notification by 12p.m. (1) one business day before your scheduled appointment, you will be charged for the missed appointment. The charge will occur for any reason even those outside of your control, ie: car troubles, illness, or transportation issues, etc.

I AGREE TO PAY A \$50 FEE IF I DO NOT CANCEL MY APPOINTMENT BY 12 P.M. THE BUSINESS DAY PRIOR TO MY APPOINTMENT

Your signature indicates that you understand the above and accept the financial responsibility for any appointment missed without prior notification.

Signature: _____

Date: _____

Print Name : _____

DOB: _____

Foothills Neurology, P.C.

Patient History

4530 East Muirwood Drive Suite 111, Phoenix, AZ 85048

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Name: _____ Date of appointment: _____

What is the main problem you are having?

Is this due to an accident? Y N Don't know Is a legal case pending? Y N Maybe

Age _____ DOB _____

PLEASE
LEAVE
THIS BOX
BLANK

Test / X-Ray

Approximate Date Done

Result

ALLERGIES: Do you have any allergies to any medicine? _____

What **MEDICINE** or **DRUG STORE PRODUCTS** are you taking?

<u>Name of Medicine</u>	<u>Dosage</u>	<u>Times per Day</u>	<u>For What</u>	<u>Approx. Date Started</u>
•				
•				
•				
•				
•				
•				

Have you **stopped any medicine** recently or used **other medicine in the past** for this problem?

Do you take birth control pills, patch or implant? Y N What? _____

PAST MEDICAL HISTORY

Do you have any other medical problems such as:

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
		Diabetes			Ulcers			Heart Problem
		Kidney Problem			Hepatitis			Stroke
		Thyroid Problem			Cancer			Arthritis
		Fibromyalgia			Seizures			Asthma/Emphysem
		TMJ			Depression			Anxiety
		Lung Disease			High Cholesterol			Headache
		Eye Disease			Osteoporosis			Chronic Pain in:
		Anemia			High Blood Pressure			<input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Other

Have you had any other surgeries, hospitalizations or other medical problems? If so list them:

Do you have any other problems for which you have been seeing a doctor or chiropractor on a regular basis?

FAMILY HISTORY

Do you have any family members with similar problems as you? Y N

Do you have any family members with?

Brain Tumor	Y	N	who? _____	Stroke	Y	N	who? _____
Seizures	Y	N	who? _____	Heart Attack	Y	N	who? _____
Headaches	Y	N	who? _____	Aneurysm	Y	N	who? _____

SOCIAL HISTORY:

Do you use tobacco? Y N How much? _____

Do you drink alcohol? Y N How much? _____

What is your occupation or major daytime activity? _____

Have you been unable to work or carry out your usual daytime activities due to this problem?

- | | | |
|--|---|--|
| <input type="checkbox"/> able to work | <input type="checkbox"/> have trouble working | <input type="checkbox"/> have missed some work |
| <input type="checkbox"/> less productive | <input type="checkbox"/> can not work | <input type="checkbox"/> have not worked since _____ |

In the **past 3 months:**

how much work or school have you missed because of this problem? _____

how many visits to the ER, Urgent Care treatment? _____

How many cups/drinks per day of: coffee _____ colas _____ tea _____ alcohol _____

Do you drink diet drinks or use Nutrasweet/Equal (aspartame) or other artificial sweeteners? Y N

Have you ever abused drugs or alcohol? Y N if yes explain:

If you are pregnant or thinking of getting pregnant please check here:

(ROS) Do you have any other symptoms that you feel are important but have not already mentioned?

___ fever/chills	___ blurred vision	___ double vision	___ jaw pain with chewing
___ chest pain	___ eye pain	___ trouble urinating	___ difficulty swallowing
___ palpitations	___ constipation	___ diarrhea	___ shortness of breath
___ joint pain	___ stomach pain	___ trouble sleeping	___ excessive sweating
___ numbness/tingling	___ dizziness	___ swollen glands	___ other (please explain)

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Medication History

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Name: _____ DOB: _____

Please Check those medications that you have **tried in the past**:

ANTI-INFLAMMATORIES Date Effectiveness

- Aspirin (Bayer, Ecotrin) _____
- Ibuprofen (Motrin/Advil/Nuprin) _____
- Naproxyn (Naprosyn/Aleve/Anaprox) _____
- Celecoxib (Celebrex) _____
- Diclofenac (Voltaren, Cambia) _____
- Indomethacin (Indocin) pills or Suppos. _____
- Ketorolac (Toradol) pills or injection _____
- Steroids (Prednisone) _____
- Other: _____

MIGRAINE MEDICINES Date Effectiveness

- Sumatriptan (Imitrex/Treximet)
(pills/shot/nasal spray) _____
- Rizatriptan (Maxalt) _____
- Eletriptan (Relpax) _____
- Frovatriptan (Frova) _____
- Zolmitriptan (Zomig) _____
- Naratriptan (Amerge) _____
- Almotriptan (Axert) _____
- Dihydroergotamine (DHE/Migranal) _____

MIXED ANALGESICS(MILD PAIN) Date Effectiveness

- Butalbital (Fioricet/Esgic Plus) _____
- Excedrine (Any form) _____
- Tramadol (Ultram/Ultracet) _____
- Other: _____

ANTICONVULSANTS Date Duration Tx Effectiveness

- Valproic acid (Depakote) _____
- Zonisamide (Zonagran) _____
- Gabapentin (Neurontin) _____
- Oxcarbazepine (Trileptal) _____
- Lamotrigene (Lamictal) _____
- Levetiracetam (Keppra) _____
- Topiramate (Topamax) _____
- Pregabalin (Lyrica) _____
- Tiagabine (Gabitril) _____
- Lacosamide (Vimpat) _____
- Other: _____

NARCOTIC PAIN MEDICINE Date Effectiveness

- Codeine _____
- Hydrocodone (Vicodin/Lortab/Norco) _____
- Oxycodone (Percocet/Endocet/Roxicet) _____
- Meperidine (Demerol) pills or shots _____
- Other: _____

TRICYCLIC ANTIDEPRESSANT Date Duration Tx Effectiveness

- Amitriptyline (Elavil) _____
- Nortriptyline (Pamelor) _____
- Doxepin (Sinequan) _____
- Trazodone (Desyrel) _____
- Other: _____

LONG ACTING NARCOTICS Date Effectiveness

- Methadone (Dolphine, Methadose) _____
- OxyContin _____
- MS Contin (Avinza/Kadian/MSIR) _____
- Fentanyl Patch (Duragesic Patch) _____
- Hydromorphone (Exalgo, Dilaudid) _____
- Other: _____

SRI/DOPA INHIBITORS Date Duration Tx Effectiveness

- Bupropion (Wellbutrin) _____
- Venlafaxine (Effexor) _____
- Milnacipran (Savella) _____
- Duloxetine (Cymbalta) _____
- Other: _____

MUSCLE RELAXANTS Date Effectiveness

- Baclofen (Lioresal) _____
- Cyclobenzaprine (Flexeril, Amrix) _____
- Tizanidine (Zanaflex) _____
- Other: _____

BETA BLOCKERS Date Duration Tx Effectiveness

- Propranolol (Inderal) _____
- Atenolol (Tenormin) _____
- Nadolol (Corgard) _____
- Metoprolol (Lopressor) _____
- Other: _____

ALTERNATIVE TREATMENTS Date Effectiveness

- Botulinum Toxin (Botox) _____
- Lidocaine 5% (Lidoderm Patch) _____
- IV Therapy for Migraine _____
- Acupuncture _____
- Trigger Point Injections _____
- Nerve blocks(occipital/neck/back) _____
- Physical Therapy _____
- Massage _____
- Oxygen _____
- Vitamins/Minerals (B, D, Magnesium) _____
- Biofeedback Meditation _____
- Ice/Heat _____
- Other: _____
- Other: _____
- Other: _____

CALCIUM BLOCKERS Date Duration Tx Effectiveness

- Verapamil (Calan,Veralan) _____
- Nifedipine(Cardene) _____
- Other: _____

ALLERGIES: Medication & Reaction

The Migraine Disability Assessment Test

The MIDAS (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS

Please answer the following questions about ALL of the headaches you have had over the past 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

- ___ 1. On how many days in the last 3 months did you miss work or school because of your headaches?
- ___ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)
- ___ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?
- ___ 4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)
- ___ 5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?
- ___ Total (Questions 1-5)

What your Physician will need to know about your headache:

- ___ A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)
- ___ B. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10=pain as bad as it can be.)

Scoring: After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B).

MIDAS Grade	Definition	MIDAS Score
I	Little or No Disability	0-5
II	Mild Disability	6-10
III	Moderate Disability	11-20
IV	Severe Disability	21+

If Your MIDAS Score is 6 or more, please discuss this with your doctor.

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