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?

- ☐ Home Phone ☐ Ok to leave message
- ☐ Work Phone ☐ Ok to leave message
- ☐ Cell Phone ☐ Ok to leave message
- ☐ Mail
- ☐ Patient Portal On-Line

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

Marital Status: Single Married Divorced Widowed Other

Primary Language:______________________________ ☐ Decline

Race:______________________________ ☐ Decline

Ethnicity:______________________________ ☐ 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______________

Foothills Neurology, P.C. Financial Responsibility

4530 East Muirwood Drive Suite 111, Phoenix, AZ 85048 Tel: (480)961-2365 Fax: (480)961-2381

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

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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 #: __________________

Foothills Neurology, P.C.

Cancellation Notice

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

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?

Name of Medicine	Dosage	Times per Day	For What	Approx. Date Started
•				
•				
•				
•				
•				
•				

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?_______________________________

Foothills Neurology, P.C. Patient History

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PAST MEDICAL HISTORY **Do you have any other medical problems such as:**

Yes	No		Yes	No		Yes	No	
		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			☐ Back ☐ Neck ☐ 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	N	Y	**who?**_______________	Stroke	N	Y	**who?**_______________
Seizures	N	Y	**who?**_______________	Heart Attack	N	Y	**who?**_______________
Headaches	N	Y	**who?**_______________	Aneurysm	N	Y	**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?

☐ able to work ☐ have trouble working ☐ have missed some work

☐ less productive ☐ can not work ☐ 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)**

Foothills Neurology, P.C. 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:____________		

MIXED ANALGESICS(MILD PAIN)	Date	Effectiveness
☐ Butalbital (Fioricet/Esgic Plus)		
☐ Excedrine (Any form)		
☐ Tramadol (Ultram/Ultracet)		
☐ Other:____________		

NARCOTIC PAIN MEDICINE	Date	Effectiveness
☐ Codeine		
☐ Hydrocodone (Vicodin/Lortab/Norco)		
☐ Oxycodone (Percocet/Endocet/Roxicet)		
☐ Meperidine (Demerol) pills or shots		
☐ Other:____________		

LONG ACTING NARCOTICS	Date	Effectiveness
☐ Methadone (Dolphine, Methadose)		
☐ OxyContin		
☐ MS Contin (Avinza/Kadian/MSIR)		
☐ Fentanyl Patch (Duragesic Patch)		
☐ Hydromorphone (Exalgo, Dilaudid)		
☐ Other:____________		

MUSCLE RELAXANTS	Date	Effectiveness
☐ Baclofen (Lioresal)		
☐ Cyclobenzaprine (Flexeril, Amrix)		
☐ Tizanidine (Zanaflex)		
☐ 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:____________		

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)		

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: ____________			

TRICYLIC ANTIDEPR	Date	Duration Tx	Effectiveness
☐ Amitriptyline (Elavil)			
☐ Nortriptyline (Pamelor)			
☐ Doxepin (Sinequan)			
☐ Trazodone (Desyrel)			
☐ Other:____________			

SRI/DOPA INHIBITORS	Date	Duration Tx	Effectiveness
☐ Bupropion (Wellbutrin)			
☐ Venlafaxine (Effexor)			
☐ Milnacipran (Savella)			
☐ Duloxetine (Cymbalta)			
☐ Other:____________			

BETA BLOCKERS	Date	Duration Tx	Effectiveness
☐ Propranolol (Inderal)			
☐ Atenolol (Tenormin)			
☐ Nadolol (Corgard)			
☐ Metoprolol (Lopressor)			
☐ Other:____________			

CALCIUM BLOCKERS	Date	Duration Tx	Effectiveness
☐ Verapamil (Calan,Veralan)			
☐ Nicardipine(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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