Foothills Neurology New Patient Registration

4530 E. Muirwood Drive Suite 111, Phoenix, AZ 85048 (480) 961-2365 Fax (480) 961-2382

Name: _____ Date of Birth: _____

Address: _____

Gender: M F

Home phone: (_____)_____

☐ Home phone is same as cell phone number

Mobile phone: (_____)_____ ☐ None

Can we send you text reminders? Y N

Work phone: (_____)_____

Email: _____ ☐ No e-mail

What is your preferred way for us to contact you?

- ☐ Home phone ____ok to leave a message
- ☐ Work phone ____ok to leave a message
- ☐ Cell phone ____ok to leave a 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 Number — Cross Streets or Address or Phone

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: _____

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_____

Financial Responsibility

4530 E. Muirwood, Suite 111, Phoenix, AZ 85048 (480) 961-2365 Fax (480) 961-2382

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.

4530 E. Muirwood Drive Ste. 111, Phoenix, Arizona 85048
(480) 961-2365

Privacy Notice

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.

4530 East Muirwood Drive ▪ Suite 111 ▪ Phoenix, Arizona ▪ 85048 Phone (480) 961-2365 Fax (480) 961-2382

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: _____

Stuart J. Hetrick, DO Scot Fechtel, MD Padma Mahant, MD Timothy Visser, ND Susan G. Hawrylkiw, NP
Leigh Gressley, NP Amber McLouth, PA-C Robin Adamson, PA-C Melinda Preston, Psy NP Mary Diedrich, PT

Foothills Neurology, P.C.

Stuart Hetrick, DO 4530 E. Muirwood Drive, Suite 111, Phoenix, AZ 85048

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

Have you had any Tests done already? (e.g., MRI, Cat scan, EMG, X-rays, Ultrasound, etc...)

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?** _____

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/emphysema
___	___	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)**

Medication History

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 last 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.