NOVELLO SPECIALTY CLINIC
Healthcare Reimagined.

REGISTRATION FORM (Neurology)

Today's Date:_____ Primary Care Provider:_____

PATIENT INFORMATION

Patient's Name:_____Marital Status: S M D W

Address:_____

City:_____State:_____Zip Code:_____

Home Phone #:_____Cell Phone #:_____Social Security #:_____

Date of Birth:_____EmailAddress:_____

Employer:_____Occupation:_____

Pharmacy:_____Pharmacy Phone #:_____

INSURANCE INFORMATION

Primary Insurance:_____

Subscriber's Name:_____Subscriber's DOB:_____

Relationship to Patient:_____ Policy #:_____Group #:_____

Secondary Insurance:_____

Subscriber's Name:_____Subscriber's DOB:_____

Relationship to Patient:_____Policy #:_____Group #:_____

EMERGENCY CONTACT ☐ **HIPAA** ☐ **GUARDIAN** ☐

Name of Contact:_____Relationship to Patient:_____

Contact Phone #:_____Alternate Phone #:_____

RELEASE OF MEDICAL RECORDS

☐ Do not release any information to anyone

☐ I authorize information to be released to:

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

Do you prefer a detailed message or a brief message asking you to call back?

☐ Leave a full message (if greeting doesn't verify whom we are calling only a call back may be left) ☐ Call back only

_____ _____

Patient/Guardian Signature Date

_____

Print Name

Medications:

Please list any medications, including items such as Aspirin, Vitamins/Supplements, Laxatives, etc.

Name Dosage/Strength Frequency How long have you taken this medication?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any Drug Allergies or Sensitivities? Yes _____ No _____

***If yes**, please list the name of the medication and the reaction or side effect*

_____

_____

_____

_____

Neurological History

At any time, have you had any of the following?

	Yes	No
Confusion	___	___
Fainting	___	___
Falls	___	___
Frequent Headaches	___	___
Memory Issues	___	___
Numbness	___	___
Seizures	___	___
Weakness of arm/leg	___	___
Visual Issues	___	___

Medical History:

Please list any medical conditions and any significant illnesses not listed above

_____

_____

_____

_____

_____

Previous Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Mother	___ Living	___Deceased	Age___	If deceased, cause of death: _____
Father	___ Living	___Deceased	Age___	If deceased, cause of death: _____
Brother	___Living	___ Deceased	Age___	If deceased, cause of death: _____
Brother	___Living	___ Deceased	Age___	If deceased, cause of death: _____
Brother	___Living	___ Deceased	Age___	If deceased, cause of death: _____
Sister	___Living	___ Deceased	Age___	If deceased, cause of death: _____
Sister	___Living	___ Deceased	Age___	If deceased, cause of death: _____
Sister	___Living	___ Deceased	Age___	If deceased, cause of death: _____
Children	___Living	___ Deceased	Age___	If deceased, cause of death: _____
Children	___Living	___ Deceased	Age___	If deceased, cause of death: _____
Children	___Living	___ Deceased	Age___	If deceased, cause of death: _____

Family History of Neurological Disease:

Brain Aneurysm	Yes or No	Relationship: _____
Cancer	Yes or No	Relationship: _____
Cerebral AVM	Yes or No	Relationship: _____
Clotting Disorder	Yes or No	Relationship: _____
Dementia	Yes or No	Relationship: _____
Depression	Yes or No	Relationship: _____
Diabetes	Yes or No	Relationship: _____
Migraine	Yes or No	Relationship: _____
Multiple Sclerosis	Yes or No	Relationship: _____
Muscular Dystrophy	Yes or No	Relationship: _____
Parkinson's Disease	Yes or No	Relationship: _____

Tics	Yes or No	Relationship: _____
Tremor	Yes or No	Relationship: _____
Seizure	Yes or No	Relationship: _____
Stroke	Yes or No	Relationship: _____

Social History:

Are you currently a tobacco user? Yes _____ No _____ If yes, what type? Cigarettes ___ Vape___ Chew___

Are you a former tobacco user? Yes _____ No _____ If yes, when did you quit? Year _____ Month _____

Do you consume alcohol? Yes _____ No _____ If yes, how often? _____ How many drinks? _____

Do you use drugs other than those for medical reasons? Yes _____ No _____If yes, how often? _____

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PATIENT RESPONSIBILITY CONSENT FORM

INDIVIDUAL'S FINANCIAL RESPONISIBILITY

- I understand that I am financially responsible for my health insurance deductible, co-insurance, or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

FORMS AND FEES

- There will be a fee for completion of forms, such as FMLA, Disability, Power of Attorney, Health Assessment Certifications, Handicap Parking, Life Insurance, etc. Payment is due when the forms are picked up. A minimum of three business days is required for completion. Fees will start at $25 and will vary depending on the type of form.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I hereby authorize and direct payment of my medical benefits to Novello Specialty Clinic on my behalf for any services furnished to me by the providers.

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

- I hereby authorize Novello Specialty Clinic to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical providers.
- By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AID/HIV and medicines used to treat mental health issues such as depression.

MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Novello Specialty Clinic. I authorize any holder of medical or other information about me to release to Medicare and its agent any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____

Print Name of Patient, Authorized Representative or Responsible Party