PATIENT REGISTRATION

COMPLETE ALL AREAS – MAKING SURE TO INCLUDE YOUR SOCIAL SECURITY NUMBER!

Last Name______________________________ First Name ______________________ MI________

SS# ______________________________ Home Phone (___)__________ Other Phone (___)__________

Home Address______________________ City______________________ State________ Zip Code________

Mother's Maiden Name__________________ Your Maiden Name______________________________

Birthdate ____-____-____ Gender_________ Race_________ Native language _________ Marital Status S M D W

Email address: ____

PATIENT EMPLOYER INFORMATION Full Time____ Part Time ____ Retired____ Approx. Retirement Date ______________

Employer______________________________ Employer Address______________________________

City ______________________ State _________ Zip _________ Employer Phone (___) ____________________

GUARANTOR INFORMATION Birth date ______-______-______ SS#______________________

Name ______________________________ Relationship ___________ Home Phone__________________

Address______________________________ Cell Phone__________________

City______________________________ State______________ Zip______________

Employer ____________________ Employer Address______________________________

City ______________________ State ___________Zip________ Employer Phone (___)__________________

INSURANCE INFORMATION ***Smartt Neurology requires a copy of insurance card at time of visit.***

Primary Insurance /Address______________________________ Telephone (___)______________

Policyholder Last Name__________________ First Name__________________ Relationship__________________

Date of Birth__________________ Group #__________________Member #__________________

Secondary Insurance /Address______________________________ Telephone (___)______________

Policyholder Last Name__________________ First Name__________________ Relationship__________________

Date of Birth__________________ Group #__________________Member #__________________

WORKMAN'S COMP. INFORMATION

Company Name______________________________ Claim # ______________________

Agent/Adjuster______________________________ Phone (____) ______________________

EMERGENCY CONTACT (nearest relative or friend not living with you)

Relation to Patient ____________________ Last Name ____________________ First ____________________

Home Address ____

City ____________________ State ______ Zip _________ Home Phone (___)__________ Work Phone (___)__________

SMARTT NEUROLOGY, PC

Background Information Form

****PLEASE PRINT – complete in blue or black ink. Make sure to complete forms entirely!****

NAME______________________________________

Primary Physician: **What is the name and address of your primary care physician?**

Name______________________________ Address______________________________________ Phone________________

Other Physicians: **Please list the names and addresses of other physicians you have seen in the past 3 years.**

Name______________________________ Address______________________________________ Phone________________

Name______________________________ Address______________________________________ Phone________________

Name______________________________ Address______________________________________ Phone________________

Main Problem: **Why are you being seen today? Please describe your symptoms.**

____

____

Current Medications: **List the medications you are taking (include over-the-counter and supplements)**

Name of medication	Strength	How many times a day?	Reason prescribed	Start date

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE SPACE PROVIDED ON THE BACK OF THIS FORM

Allergies: **List all allergies (including medications)**

Item or Medication	Reaction	Date

Previous Hospitalizations: **List all hospitalizations**

Reason for hospitalization	Hospital	Date

Previous Surgeries: **List all surgeries**

Procedure name	Hospital	Date

MEDICATION LIST for: ______________________________

Medication name	Strength	How many times a day	Reason prescribed	Start date

Other Conditions or Symptoms: **Please circle all that apply.**

Please explain any items you circled below. (Use additional sheets of paper, if needed.)

General	weight change · fatigue · energy loss · fevers · cold or heat intolerance · night sweats · cancer · changes in hair · changes in nails · pain · failure to gain weight · short stature	None
Sleep	snoring · stop breathing · daytime sleepiness · trouble falling asleep · frequent awakenings · trouble staying asleep · nightmares · movement during sleep	None
Immune	Frequent infections · swollen glands · runny nose · allergic reactions · lupus	None
Allergies	latex · lidocaine · aspirin · sulfa · penicillin · vaccines · bee stings · eggs · hay fever · seafood · peanuts · milk · thimerosal · anti-seizure medicines · other	None
Eyes	cataracts · glaucoma · blurred vision · blindness · light sensitivity · night blindness · double vision · lazy eye · drooping eyelids	None
Skin	rash · itching · color change · flushing	None
ENT	hearing loss · ringing in ears · sinus problems · sore throat · changes in voice · trouble swallowing · tonsillitis · difficulty chewing · abnormal teeth	None
Heart	Murmur · chest pain · high blood pressure · circulation problems · blocked arteries · irregular heartbeat · rheumatic fever · swelling in feet	None
Respiratory	shortness of breath · wheezing · cough · asthma · emphysema · pneumonia · tuberculosis · positive TB skin test	None
Digestive	abdominal pain · heartburn · ulcers · loss of appetite · nausea · vomiting · constipation · diarrhea · bloating · blood in stools · Diverticulitis · gall bladder problems · appendicitis · liver problems · Pancreatitis · hernia · choking	None
Genital Urinary	More than one urination at night · loss of bladder control · frequent urination · painful urination · difficulty passing urine · blood in urine · kidney stones · kidney failure · prostate trouble · swollen testicle · discharge from penis	None
Endocrine	Diabetes · thyroid problems · high cholesterol · hormone problems · obesity · steroid treatment	None
Reproductive	problems with sexual function · menstrual problems · pregnancy · miscarriages · breast lump · nipple discharge · abortions · severe cramps · sexually transmitted diseases	None
Hematologic	anemia · bruise easily · bleed easily · blood clots · leukemia	None
Musculoskeletal	Muscle weakness · muscle pain · leg cramps · muscle twitching · stiffness · arthritis · joint pain · gout · neck pain · back pain · slipped disc · osteoporosis · fractures · bone disease	None
Neurologic	Headaches · migraines · dizziness · fainting · stroke · convulsion · seizures · epilepsy · head injury · meningitis · memory loss · trouble concentrating · trouble speaking · trouble understanding · handwriting changes · paralysis · tremor · problems with coordination · trouble walking · pinched nerve · neuropathy · numbness · tingling · seeing or hearing things that aren't there · multiple sclerosis · Guillain-Barre syndrome · tics	None
Psychiatric	Behavior changes · mood changes · depression · anxiety · feeling down in the dumps · bipolar · nervous breakdown · alcoholism · drug addiction · hyperactivity · impulsivity · oppositional behavior · obsessive · poor attention span · aggressive behavior	None
Other		None

Other Information:

Marital status (circle one): single married divorced separated widowed

Who else lives with you? ______________________________

Work status (circle one): working unemployed on leave on disability retired

What is your occupation (or former occupation, if not currently working)? ______________________________

____

How many years did you go to school? ____________ Name of the last school you attended? ______________________

Are you (circle one): right handed / left handed / both Religious preference ______________________

If you use tobacco products (circle all preferred products) cigarettes cigars pipe chewing

How long have you used tobacco products? ____________ Quantity per day:__________

Have you quit using tobacco products? yes no When did you quit? ______________

Do you drink alcohol (circle one)? yes no How many drinks per week? _____ Have you ever been a heavy drinker? yes no

Do you drink caffeine? _____ How drinks per day? ______ Have you ever used recreational drugs? ____________________

Have you been exposed to any environmental hazards? ________ If so, what? ______________________________

Is there any pending legal action related to your current condition? Please explain. ______________________________

Family History: Do any of your blood relatives have the same condition that you have? If so, who?

____

____

Please list medical conditions in your family (use additional paper if necessary):

Relationship	Living?	Age	List current health conditions	Cause of death
Father	Y N			
Mother	Y N			
Paternal Grandfather	Y N			
Paternal Grandmother	Y N			
Maternal Grandfather	Y N			
Maternal Grandmother	Y N			
Sister	Y N			
Sister	Y N			
Sister	Y N			
Brother	Y N			
Brother	Y N			
Brother	Y N			

Signature of patient: ____ Date: ________________

Names of person completing this form (please print):______________________ Relationship to patient: ____________

Signature of person completing this form: ____________________________ Date: ________________

(Office Use Only)

Reviewed by: ***Date:***

revised 03/08/2011