ROCHESTER NEUROLOGY, P.C.
REGISTRATION FORM

Name____Date______________________________

SSN_________________________________ DOB_____/______/_______ Sex M F Marital Status S M W D

Address___________________________________City______________________State________Zip____________

Tele(H)________________________(W)___________________________(C)______________________________

Preferred Phone_____________________________________Email______________________________________

Referring Physician____Phone____________________________

Primary Care Physician (if different)_____________________________________Phone_________________________

Employer____

Address____

Emergency Contact______________________________Relationship________________Phone_________________

If your insurance carrier requires a referral/authorization from your Primary Physician, you MUST provide one.

Primary Insurance_________________________________Policy #_______________________________________

Name of Insured_______________________________________Relationship to Patient_________________________

SSN of Policy Holder_____________________DOB_____/_______/______Phone_______________________________

Insurance Phone____

Secondary Insurance________________________________Policy #____

Name of Insured____Relationship to Patient__________________________

SSN of Policy Holder______________________DOB_____/_______/______Phone________________________________

Insurance Phone____

All patients must sign the first 4 sections.

Medicare patients must sign the 5th section as well.

1. INSURANCE WAIVER

I understand that my insurance only covers certain procedures. My insurance may determine that a particular procedure may not be covered, in which case I am responsible for payment for that procedure. I understand that if my insurance has lapsed or if I am not covered for any reason that I will be responsible for my office visit and any uncovered procedures.

Signed____Date_________________________________

2. HIPAA

I have read and understand my rights as described in the HIPAA documentation. An office copy of this was provided with my registration paperwork.

Signed____Date__________________________________

3. INSURANCE AUTHORIZATION AND ASSIGNMENT: I authorize the release of any medical and/or other information necessary to process this claim. I also request payment of insurance benefits either to myself or Rochester Neurology, PC should it elect to accept assignment; otherwise, payment is due upon services.

Signed____Date__________________________________

4. COPAY AND CANCELLATION POLICIES: I understand that failure to pay the copay at time of service will result in an additional $15 charge. I understand I may be charged a $25 fee for failure to give 24 hours notice for cancelled or missed appointments. I understand there is a **mandatory** $50 fee for failure to give 24 hours notice for cancelled or missed ***EEG*** appointments. I understand these charges are my responsibility and they cannot be billed to or paid by any insurance company. I understand 3 missed appointments may result in discharge from the practice.

Signed____Date__________________________________

5. MEDICARE ONLY: I authorize any holder of medical or any other information about me to release Social Security Administration and the centers for Medicare and Medicaid services and/or its carriers, or to the billing agent of this physician, any information used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signed____Date__________________________________

ROCHESTER NEUROLOGY, P.C.
REGISTRATION FORM Part II

Name____

Please indicate the reason for your appointment____

List any current medication, including over the counter preparations and supplements, you have taken recently___________

Allergies (drugs, latex, food and reaction)____

Medical conditions/illnesses (please include dates)____

Surgeries/hospitalizations (please include dates)____

Recent X-rays or other tests____

Pharmacy name, address and phone____

Do you smoke? Y N If so, how much?____

Did you smoke? Y N If so, how much and for how long did you smoke?______________________________

Do you drink alcohol? Y N If so, how much and how often?____

Do you use recreational drugs? Y N Do you exercise? Y N How much and how often?_____________________

Date of last menses______________________________Could you be pregnant?_________________________

Are you right or left handed? R L Height_________________________ Weight___________________________

Do any of your blood relatives have the following? If so, please specify which family member:

Heart disease
Cancer
Kidney disease
Aneurysm
Muscle Disorder
Shaking
Mental illness
High blood pressure
Arthritis
Thyroid disease
Stroke
Sensory Disorder
Attention Deficit Disorder
Seizures
Diabetes
Bleeding disorder
Brain Tumor
Dementia
Incoordination
Headaches

Age of Mother and father (if deceased, state cause)____

Comments____

Have you recently experienced any of the following?:

Fever
Visual change
Ringing in ears
Change in smell
Chest pain
Allergies
Abdominal pain
Problems urinating
Bone problems
Shooting pain/sciatica
Bleeding or bruising
Sleepiness/sedation
Depression
Memory problems
Personality changes
Dizziness or vertigo
Weakness
Shaking
Weight loss/gain
Hearing Loss
Cough
Difficulty in swallowing
Palpitations
Constipation
Black stools
Sexual problems
Neck pain
Muscle pain
Anemia
Difficulty sleeping
Headaches
Hallucinations
Difficulty speaking
Clumsiness
Numbness or tingling
Change in appetite
Earache
Sore throat
Nausea or vomiting
Shortness of breath
Diarrhea
Blood in stool
Joint pain
Low back pain
Skin problems
Fatigue
Anxiety
Change in mental acuity
Agitation or confusion
Change in taste
Unsteadiness
Stiffness or slowness

Other____