WESTERN NEURO
Arizona's Premier Brain & Spine Specialists

NEUROLOGICAL SURGERY
Hillel Z. Baldwin, M.D.
Joseph A. Christiano, Jr., M.D.
Ryan M. Kretzer, M.D.
Eric P. Sipos, M.D., F.A.C.S.
Matthew P. Wilson, M.D.

PHYSICIAN ASSISTANTS
Marie Glisson, PA-C, MPAS
Amy Miltenberger, MHS, PA-C
Chelsea L. McNally, MS, PA-C
Nicole Nelson-Bridges, MS, PA-C
Dennis Paul, MS, PA-C

NEUROSURGICAL CONSULTANT
Robert P. Goldfarb, M.D., F.A.C.S., Emeritus

MEDICAL NEUROLOGY
L. Roderick Anderson, M.D.
Diana V. Benenati, M.D.
William B. Lujan, M.D.
David R. Siegel, M.D.

NURSE PRACTITIONERS
Amy Alberts AGACNP-BC
Eddie Gilliam, PhD, CFNP

Welcome to Western Neuro

Your appointment is with:

on _____ at _____am/pm. *Please arrive at*_____

Please bring the following for your appointment:

1. The enclosed registration packet COMPLETELY filled out, signed and dated. Please bring the completed packet to your appointment. It is not necessary for you to mail the forms.
2. Your insurance card(s)
3. Your driver's license or other photo identification
4. Payment – your co-payment or patient responsibility amount is required to be paid at the time of your appointment

PLEASE NOTE: YOUR APPOINTMENT WILL BE RESCHEDULED IF YOU ARRIVE MORE THAN 10 MINS LATE AND/ OR WITHOUT YOUR COMPLETED REGISTRATION FORMS.

If you are unable to make your appointment, please call 520-881-8400 to notify our office 24-48 hours in advance.

**** MAIN LOCATION****
6567 E. Carondelet Dr., Suite 305
St. Joseph's Hospital Campus

Phone: (520) 881-8400

WESTERN NEURO
Medical History Form – NEUROLOGY

Patient's Name _____ Today's date_____ Gender: Male / Female

Age_____ Date of Birth_____ Email: _____

Name of Primary Care Physician_____

Referring Physician for today's visit_____

Pharmacy - Local (include address) _____

Mail order_____

Reason / Problem for today's visit_____

Have you visited the Emergency Room for this problem? Yes / No

If yes, which ER did you visit & when? _____

Have you seen another neurologist or doctor for this problem or received any treatments? Yes / No

Where / When / What_____

If you have had any tests for this problem please provide date(s) & location(s) – OR – circle "No Testing"

Blood work_____

X-ray_____

CT Scan_____

MRI Scan_____

EEG_____

EMG / NCV_____

Other_____

ALLERGIES – Please list all known allergies (medications, iodine, latex, nuts, etc.) with reactions – OR – circle "NKDA" (No Known Drug Allergies)

_____

_____

_____

MEDICATIONS – Please list all current medications & dose (include over-the-counter, vitamins, supplements, etc.)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.

Patient's Name _____ Today's date_____

YOUR PAST MEDICAL HISTORY – Please circle all that apply:

Neurological Illnesses:

Stroke Seizures Parkinson's Dementia Headache Muscle Disorder

Neuropathy Tremor Multiple sclerosis Brain tumor Brain aneurysm

Other_____

Heart Disease:

Heart Failure Heart Attack Atrial Fibrillation Murmur Pacemaker / Defibrillator

High Blood Pressure High Cholesterol Coronary Artery Disease Stent

Diabetes? Yes / No Type_____ Do you use insulin? Yes / No

Cancer: Where in body? Type? _____

Diagnosed when?_____

Treatment(s) received_____

Lung & Breathing Disorder:

Asthma COPD / Emphysema Other_____

Sleep Apnea? Yes / No Using CPAP or BiPAP?

Hormonal Problems:

Thyroid – Hypothyroidism / Hyperthyroidism Other_____

Gastrointestinal Disorders:

GERD Hepatitis Irritable Bowel Other_____

Hepatitis – Type?_____

Kidney Disease:

Kidney Stones Dialysis Other_____

Eye Problems:

Cataracts Glaucoma Macular Degeneration Other_____

Joint Disease:

Osteoarthritis Rheumatoid Arthritis Lupus Other_____

Back Pain Neck Pain Joint replacement_____

Major Infections:

Meningitis Pneumonia Urinary Infections Other_____

YOUR SURGICAL HISTORY – Please list all surgeries / procedures – OR – circle "No Previous Procedures"

_____

_____

_____

Patient's Name _____ Today's date_____

FAMILY HISTORY – If deceased, please state age at death & cause of death if known:

Mother_____ Grandmother (maternal) _____
Father_____ Grandmother (paternal) _____
Sister_____ Grandfather (maternal) _____
Brother_____ Grandfather (paternal) _____

YOUR PERSONAL / SOCIAL / OCCUPATIONAL HISTORY:

Single Married Partnered Separated Divorced Widowed Number of children_____

Tobacco: CURRENT / PAST / NEVER
Cigarettes / Chew / Cigar / Pipe How much? _____How long?_____ Quit date?_____
Alcohol: CURRENT / PAST / NEVER
Beer / Wine / Hard Liquor Average # drinks per week? ___ How long?_____ Quit date?_____
Illicit Drug Use: CURRENT / PAST / NEVER Treatment for substance abuse / alcoholism? _____

OCCUPATION: Currently Employed / Unemployed / Retired / Disabled
Job Title: _____
How long have you done this job? _____
How long have you been Unemployed/ Retired / Disabled _____
What work have you done in the past? _____

EDUCATION (Please circle highest level achieved):
Elementary / Middle / High School / Jr College / Some College / College Grad / Post Grad / Other

HEALTH & SYMPTOM REVIEW (REVIEW OF SYSTEMS) Please circle any current symptoms or health problems. Some symptoms may not seem pertinent to your visit but are important for us to know:

- Fever – Chills – Fatigue – Malaise – Appetite Loss – Night Sweats – Weight Gain – Weight Loss
- Blurry Vision – Double Vision – Glasses – Contact Lenses – Change in Vision – Loss of Vision – Eye Pain
- Decreased Hearing – Difficulty Swallowing – Ear Pain – Jaw Pain – Sinus Pain – Taste Disturbance – Ringing in Ears – Vertigo – Hearing Aid(s)
- Shortness of Breath – Cough – Wheezing – Sleep Apnea (CPAP / BiPAP) - Excessive Snoring
- Chest Pain – Palpitations – Irregular Heartbeat – Fainting Spells – Leg Swelling
- Nausea – Vomiting – Diarrhea – Constipation – Bowel Accidents
- Urinary Frequent / Urgency / Accidents – Frequent Urinary Infections – Erectile Dysfunction
- Anemia – Bruising Tendency – Bleeding Tendency
- Excessive Thirst – Excessive Hunger – Cold Intolerance – Heat Intolerance
- Chemotherapy – Radiation Therapy – Recurrent Fevers – Recurrent Infections – Organ Transplant
- Back Pain – Neck Pain – Joint Pain – Muscle Aches – Muscle Cramps – Muscle Weakness – Difficulty Walking
- Rash – Itching – Dry Skin – Worrisome Skin Lesions
- Abnormal Balance – Confusion – Numbness / Tingling – Dizziness – Headache – Loss of Coordination – Memory Loss – Seizures – Tremors
- Anxiety – Depression – Hallucinations – Changes in Behavior and/or Personality – Irritability – Sleep Disturbance– Substance Abuse

ADDITIONAL INFORMATION YOU WOULD LIKE YOUR DOCTOR TO KNOW_____

_____

_____

_____ _____

Patient's Signature / Date **Physician's Signature / Date**

Patient Registration Form - WESTERN NEURO

Please Complete All Fields

PATIENT INFORMATION

Patient's Name:[Last]_____ [First]_____ [Middle]____
Responsible Party (if not self):_____
Patient Email: _____

Residing Address:_____ City:_____ State:_____ Zip:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____ Ext:_____

Primary Care Physician:_____ Phone#:_____ Fax#:_____

Referring Physician:_____ Phone#:_____ Fax#:_____

Sex: ☐ Male ☐ Female Date of Birth:__/_____/_____ Social Security No:_____-_____-____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Other Occupation: ☐Employed ☐Full-Time Student ☐Part-Student ☐ Retired ☐Unemployed

Employer/School:[Name]_____ [Phone]_____

Spouse's:[Name]_____ [Phone]_____

Emergency Contact:[Full Name]_____ [Phone]_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name:_____

ID#:_____ Grp#:_____

Claims POBox:_____ Zip:_____

PolicyHolder Is (circle): Self Spouse Child Other:____

Policy Holder Name:_____ DOB:_____

Policy Holder's Employer:_____

Policy Holder's SSN:_____-_____-_____

SECONDARY INSURANCE

Insurance Name:_____

ID#:_____ Grp#:_____

Claims POBox:_____ Zip:_____

PolicyHolder Is (circle): Self Spouse Child Other:____

Policy Holder Name:_____ DOB:_____

Policy Holder's Employer:_____

Policy Holder's SSN:_____-_____-_____

INDUSTRIAL/WORKERS COMPENSATION

Carrier Name:_____ Claim#:_____ Date of Injury:_____

Claims Billing Address:_____ City:_____ State:_____ Zip:_____

Employer at Time of Injury:_____ Adjuster Name:_____ Ph#:_____

RELEASE OF MEDICAL RECORDS AND ASSIGNMENTS OF BENEFIT

I hereby authorize the Physicians of Western Neurosurgery Ltd. to release any information acquired in the course of my examination or treatment to my insurance company, HMO, AHCCCS (AZ Health Care Cost Containment Systems) hospitals, or referring Physician's office. I authorize the assignment of benefits and payment directly to Western Neurosurgery Ltd. and agree to pay any and all charges that exceed or that are not covered by insurance, including an attorney and collection fees incurred for collection purposes. Photo copy of this release and assignment is valid as the original.

Signature:_____ Date:_____

**Relation to patient if above signature is not patient's:_____

Notice of Office Privacy Practices- WESTERN NEURO

Please Complete All Fields

Patient Privacy: Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice; however, we would like your acknowledgement that you have been notified that the practice has a Notice of Privacy Practices.

Health Insurance Portability and Accountability Act

Please list the names of all individuals you would like to be able to receive and/or discuss your medical information with our practice. This authorizes us to leave messages concerning appointments, lab results, and release information concerning your health, to the individuals at the numbers you list on this form.

NAME / RELATIONSHIP PHONE

_____

_____

_____

_____

The Health Information Technology for Economic and Clinical Health Act

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17 2009, to promote the adoption of Meaningful Use for health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions, and strengthen the civil and criminal enforcement of the Health Insurance Portability and Accountability Act (HIPAA).

In order to comply with the above act, Western Neurosurgery, LTD. is required to obtain specific documentation for your electronic medical record.

Ethnicity (Please circle one):

LATINO/HISPANIC NON- LATINO/HISPANIC

Race (Please circle one):

AMERICAN INDIAN/ALASKA NATIVE NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

ASIAN WHITE

BLACK OR AFRICAN AMERICAN DECLINED / OTHER: _____

Please sign and date to indicate that you have read and understand the information provided on our office's privacy practices, and that our office has permission to contact the individuals you listed to receive and/or discuss your medical information with our practice.

Patient's Name:_____

Signature:_____ Date:_____

**Relation to patient if above signature is not patient's:_____

Patient Responsibility Policy- WESTERN NEURO

Please Complete All Fields

PATIENTS ARE RESPONSIBLE **FOR CHECKING WITH THEIR CURRENT INSURANCE COMPANY** TO VERIFY COVERAGE AND CONTRACT INFORMATION. We are not contracted with all insurance plans.
FEES: We must comply with insurance company regulations, consequently our fees are fixed. If your insurance DOES NOT PAY 100% of our contracted fee, **you are responsible for your account balance prior to each visit**. If we are NOT contracted with your insurance plan, payment is expected at the time the service is rendered.
CO-PAYS: **All co-pays are collected when you arrive for your appointment. If you are not prepared to make your co-pay at the time of service, your appointment will be rescheduled.**
SELF PAY: If you will be paying for the visit out of pocket, the doctors require payment at the time service is rendered.
PATIENT BALANCE: ALL ACCOUNT BALANCES, AFTER INSURANCE HAS BEEN PROCESSED, **ARE DUE IN FULL WITHIN 30 DAYS**.
COLLECTIONS: Any patient that has been placed in COLLECTIONS must pay any prior balance owed to the practice as well as the collection agency fee PRIOR to being seen again.

Please sign and date below to indicate that you have read and understand the patient's financial responsibility outlined above.

Signature:_____ Date:_____

**Relation to patient if above signature is not patient's:_____

PHARMACY INFORMATION

Please provide your pharmacy information:

Prescription refills are provided only for medications prescribed by Western Neurosurgery, LTD physicians. If you need a refill, please call your pharmacy. If your prescription is a narcotic, please call our office 72 hours prior to running out of your prescription. Patients are responsible for picking up prescriptions from Western Neurosurgery, LTD during normal business hours.

Your Name:_____

Pharmacy Name:_____

Pharmacy Phone Number:_____ Fax:_____

Pharmacy Address:_____

Please sign and date below to indicate that you have read and understand the prescription refill policy.

Patient's Name:_____

Signature:_____ Date:_____

**Relation to patient if above signature is not patient's:_____