Northland Neurology & Myology, PA

PLEASE READ: This registration paperwork is required for your appointment with Northland Neurology. Please note we are a private practice with limited access to outside medical records. Thank you for your understanding and cooperation!

Patient Information

Last Name: ______________________________________ First: _________________________________ M/I ________

Birth Date: _______________________ Social Security #: ____________________________ Sex: _______ M ________ F

Ethnicity/Race: _____________________ Primary Language: _____________________ Marital Status: ___________

Address: __________________________________ City/State: ____________________________ Zip: _______________

Home Phone: _____________________________________ Cell/Work Phone: ___________________________________

Email Address: ____

If patient is a child; Parent's Name: _____________________ Primary/Referring Doctor: ______________________

Occupation: ____ If retired; year of retirement: ______________________

Employer Name and Address: ____

Insurance Information

❖ **Please select your insurance type**

_____ Private employer sponsored insurance _____ Medicare

_____ Medical Assistance/MNCare _____ Self Pay (no insurance)

Workers Comp_____: Date of injury _____________ Auto Accident_____: Date of Injury _____________

❖ **Please provide your insurance details if insurance card is not presented at registration**

1. Primary Insurance Name & Address: ____

Subscriber/Policy #: ____ Group #: _______________________________________

Subscriber (circle one): Self Spouse Father Mother No Relation

2. Secondary Insurance Name & Address: ____

Subscriber/Policy #: ____ Group #: ____

Subscriber (circle one): Self Spouse Father Mother No Relation

❖ **If the insurance is through a spouse or patient is a minor, the following section is mandatory**

Spouse/Parent Name: ____

Spouse/Parent Social Security #:___________________Spouse/Parent Birth Date: _____________________________________

Northland Neurology & Myology, PA

Assignment of Benefits Form

Name of Patient/Responsible Party (print):____

Social Security Number: ____

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to Northland Neurology & Myology, PA for any medical services provided to me by that organization.

I authorize the release of any medical information or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization the Health Care Financing Administration, my insurance carrier, or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company, or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

By signing this document, I also acknowledge that I have read and/or received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print): ____

Relationship to the Insured: ____

Signature of Insured: ____ Date: ____________________

1000 E. 1st Street, Suite 105 Phone 218-722-1122

Duluth, MN 55805 Fax: 218-722-0600

Comprehensive History Questionnaire and Physical Exam

Current Medical Problems

Please list the medical problem for your visit. Describe your current symptoms.

____

____

Do you use tobacco?

No ______ Please *circle* one: Former Smoker Never Smoker

Yes ______ Please *circle* one: Current every day Smoker Current some day Smoker

I use smokeless tobacco ______ Are you ready to quit? No _______ Yes______

What is your typical alcohol consumption?

______ drinks per day week month

Current Medications

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets, or vitamin supplements). List name, dosage, and quantity.

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

What pharmacy do you use? Name: ____________________________________ City/Location: ______________________________

Medication Allergies, Sensitivities, and Intolerances

Do you have any medication allergies, sensitivities, and/or intolerances? No _________ Yes_________
If yes, please list what it is and how it affects you:

____

____

Other Medical Care: If you are being treated for any other illness or medical problems, please describe the problem(s) and write the name of the physician, health practitioner, or medical facility treating you.

____ ____

____ ____

____ ____

Height: ____________ **Weight**: ____________

Name ____ Date ______________________

Medical History Check List

Surgeries with approx.. age:	
Accidents with approx.. age:	
Serious illness w/ age of onset:	
Infectious Diseases:	Gonorrhea HIV/AIDS Hepatitis B Hepatitis C TB Other:
Family History:	Allergies Cancer Diabetes Heart Disease Strokes Hypertension Other:

Review of Symptoms:

PLEASE X ANY CURRENT SYMPTOMS

Cardiovascular

___ Ankles swell
___ Chest pain
___ Chest pain on effort
___ Heart problems
___ Hypertension
___ Skipping/irregular heart beat

Head and Neck

___ Double vision
___ Failing vision
___ Headaches
___ Pain in ears
___ Persistent neck rigidity
___ Ringing in ears
___ See "floating lights"
___ Severe hearing loss

Musculoskeletal

___ Back pain
___ Joint/muscle problem
___ Physically handicapped/limited
___ Shoulder pain

PLEASE X ANY CURRENT SYMPTOMS

Neuropsychological

___ Any alcohol problem
___ Any burning sensation
___ Any drug problem
___ Any memory loss
___ Any muscle jerking
___ Any numbness
___ Any psychiatric problem
___ Any seizures
___ Any shaking
___ Any strokes
___ Any tingling sensation
___ Depression
___ Disturbance in walking
___ Dizzy spells
___ Paralysis/weakness
___ Personality changes
___ Psychotherapy/counseling
___ Speech disturbances

Pulmonary

___ Have chronic cough
___ Have night sweats
___ Sit up to breathe easier
___ Spit up blood
___ Wheezing

PLEASE X ANY CURRENT SYMPTOMS

Stomach and Intestines

___ Any black tarry stools
___ Any blood from rectum
___ Any chronic diarrhea
___ Appetite loss
___ Chronic abdominal pain
___ Habitual Constipation
___ Heartburn
___ Persistent nausea
___ Skin turns yellow
___ Vomit blood

Urinary Tract

___ Any blood in urine
___ Any leakage of urine
___ Any retention of urine
___ Frequent night urination
___ Frequent urination
___ Hard to start urinary flow
___ Scanty urination

OB GYN (women)
Last menstrual period Start:
____
___ # of pregnancies
___ # of living children

Name ____ Date ____________________