PATIENT REGISTRATION FORM

Please complete all sections. The patient, if an adult is regarded as being responsible for all charges generated.

Date: _____

Last Name: _____ First: _____ S.S#: _____

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

Sex: _____ Age: _____ Date of Birth: _____ Marital Status: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____ Pharmacy: _____ Phone: _____

Emergency contact (not living with you): Last: _____ First: _____

Relationship to Patient: _____ Phone: _____ Alt: _____

Address: _____

INSURANCE INFORMATION

Person responsible for account: Last: _____ First: _____

Relationship to Patient: _____ Date of Birth: _____ S.S #: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Contact #: _____

Subscriber #: _____ Group #: _____

Name of Insured on Card: _____

Responsible party agrees to fill out new form when any of the above information changes. Wrong information may result in incorrect filing and subsequent charges.

SECONDARY INSURANCE

Insurance Company: _____ Contact #: _____

Subscriber #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize and direct my insurance carrier to make payment directly to NeuroDiagnostic Center – Ignacio M. Carrillo-Nunez, M.D. for any insurance benefits due to me under my insurance plan. I understand and agree that I am financially responsible for any charges not covered by my insurance. Any unpaid balance not received within 45 days will be my responsibility. I authorize the release of any medical or other information necessary to process insurance claims and secure payment of benefits. I also authorize the use of my signature on all insurance submissions. If the patient is a minor, I, as the legal guardian, give consent for examination and treatment for this and all future services provided. I acknowledge that I have received the Notice of Privacy Practices and have been given the opportunity to review it.

Responsible Person/Patient Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ Date of Birth: _____
Last First

1. AGREEMENT FINANCIAL, POLICY TO PAYMENT POLICY I acknowledge that I received a copy of Neurodiagnostic Center financial policy and agree to the terms of payment due

2. AUTHORIZATION TO RELEASE INFORMATION I authorize release of my medical record information pursuant to applicable federal and state law, rules and regulations, to third party payers and other providers participating in my care that agree to treat any information in a confidential manner in accordance with all applicable federal, state and local laws. I further authorize any other individual or entity that has provided health care to me to release to Neurodiagnostic Center, any and all of' my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time except to the extent that action has been taken in reliance on the consent.

3. ASSIGNMENT OF BENEFITS I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Neurodiagnostic Center for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents and information needed to determine these benefits payable for related services

4. GUARANTEE OF PAYMENT I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to Neurodiagnostic Center are not paid according to this financial policy the account shall be deemed delinquent. In the event that I default on payment of my account I understand I am responsible for any and all cost incurred on the collection of my account including court cost and reasonable attorney's fee. It the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amount in default.

Signature:_____ **Date**:_____
(Please sign here – Patient or responsible party)

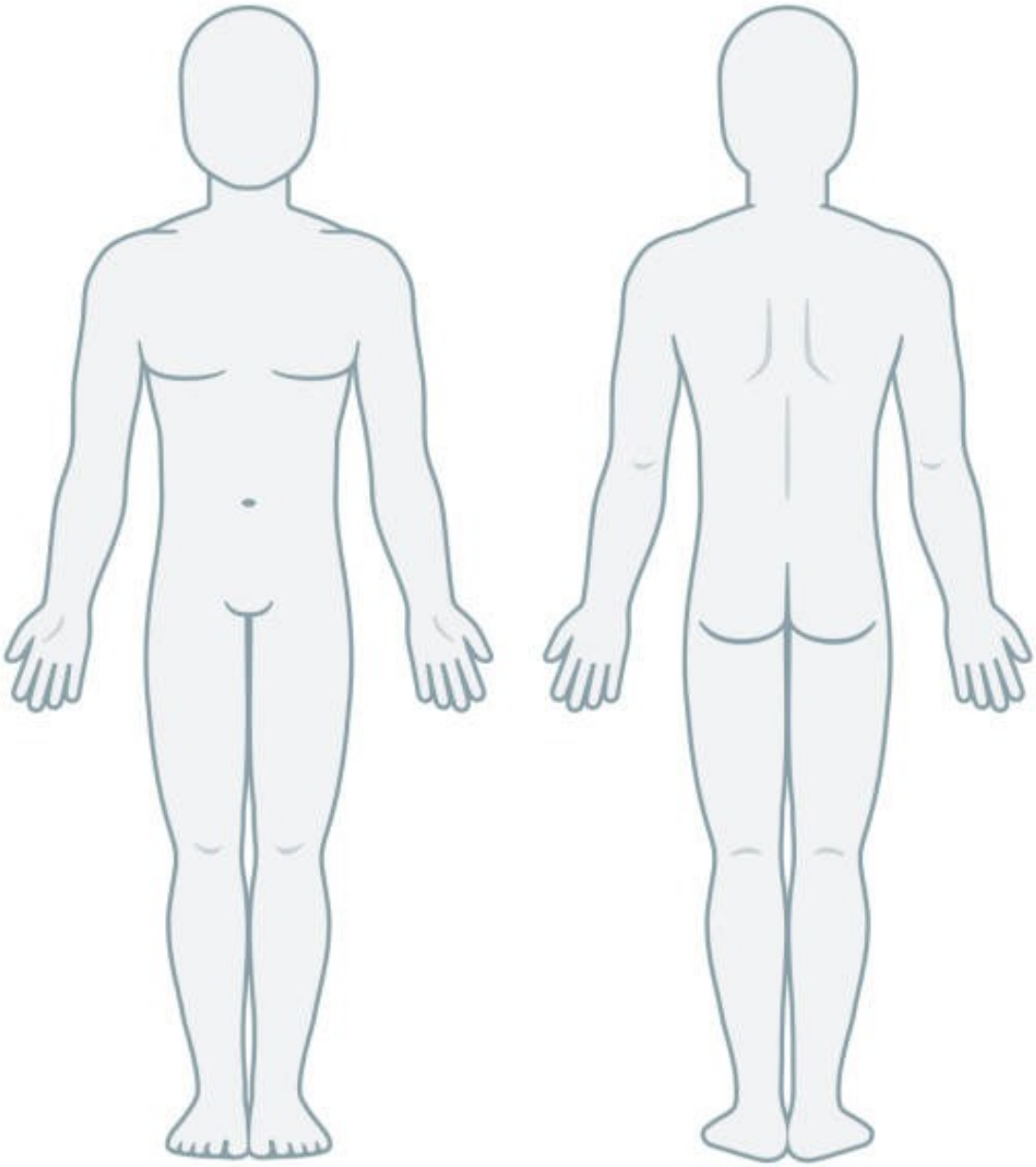
Responsible Party Name:_____
(Please print name of Responsible Party if different from Patient)

MARK THE AREAS WHERE YOU FEEL THE DESCRIBED SENSATIONS

USE THE APPROPRIATE SYMBOL, MARK AREAS OF RADIATIONS

INCLUDE ALL AFFECTED AREAS.

NUMBNESS: ═══ PINS & NEEDLES: □□□ BURNING: XXX STABBING: ////



MEDICAL HISTORY

Date: _____

Name: _____

D.O.B: _____ Age: ____ Sex: ____ Single / Married / Divorced / Widowed / Separated

Race: _____ Ethnicity: _____ Language: _____

Address: _____

Home Phone: _____ Occupation: _____ Work Phone: _____

If married, spouse's name: _____

Children's names and ages: _____

_____

Allergies to Medications, X-Ray Dyes, or Other Substances? ☐ **No** ☐ **Yes**

If Yes, please list name of medicine and type of reaction

Name	Reaction
_____	_____
_____	_____

Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	

Past Medical History and Review of Systems

Please check if you have had any problems with or are presently experiencing any of the following:

☐ High Blood Pressure	☐ Bronchitis	☐ Change in Bowel Habits	☐ Arthritis
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight gain/loss	☐ Low back problems
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Difficulty Urinating
☐ Heart disease	☐ Tuberculosis	☐ Gall bladder disease	☐ Skin diseases
☐ Chest pain/tightness	☐ Hay Fever	☐ Colitis	☐ Blood disorders
☐ Shortness of breath	☐ Headache	☐ Hepatitis or Jaundice	☐ Venereal diseases
☐ Swollen ankles	☐ Thyroid Disease	☐ Anxiety	☐ Depression
☐ Palpitations	☐ Indigestion	☐ Head or neck radiation	☐ Anemia
☐ Lightheadedness	☐ Nausea	☐ Abdominal discomfort	☐ Alcohol abuse
☐ Frequent urination	☐ Vomiting	☐ Kidney disease	☐ Drug abuse
☐ Rheumatic fever	☐ Constipation	☐ Kidney stones	☐ Gout
☐ Asthma	☐ Diarrhea	☐ Impotence or Erectile Dysfunction	☐ Other

_____

_____

GYNECOLOGIC AND OBSTETRIC HISTORY

Age at onset of periods: _____ Frequency: _____ Length of Period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding ☐ No ☐ Yes (If yes, please describe) _____

Leakage of Urine ☐ No ☐ Yes (If yes, please describe) _____

Pelvic Pain ☐ No ☐ Yes (If yes, please describe) _____

Abnormal discharge ☐ No ☐ Yes (If yes, please describe) _____

History of abnormal Pap smear ☐ No ☐ Yes (If yes, please describe) _____

Please list and supply the dates of:

Operations: _____ _____

_____ _____ _____

Hospitalization other than for surgery: _____ _____

_____ _____ _____

Immunization history-have you had:

Hepatitis B? ☐ Yes ☐ No Flu ☐ Yes ☐ No Other ☐ Yes ☐ No

Pneumovax? ☐ Yes ☐ No Tetanus ☐ Yes ☐ No

When was your last:

Pap Smear? _____ Breast Exam? _____ Colon Cancer Test? _____

Mammogram? _____ Cholesterol check? _____ Prostate Exam? _____

Family History					Check if your blood relatives had any of the following	
Relation	Age	State of Health	Age at Death	Cause of Death	Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Prevention			
Do you wear seat belts?	☐ Yes	☐ No	If no, why not? _____
Do you wear a bike helmet?	☐ Yes	☐ No	N/A
Do you exercise regularly?	☐ Yes	☐ No	If yes, duration and number of times per week _____
Do you smoke?	☐ Yes	☐ No	If yes, how many packs per day _____
Do you drink alcoholic beverages?	☐ Yes	☐ No	If yes, how much per week _____
Do you drink coffee?	☐ Yes	☐ No	If yes, how many cups per day _____
Do you drink tea?	☐ Yes	☐ No	If yes, how many cups per day _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	☐ Yes	☐ No	N/A
Do you use drugs (marijuana, cocaine, etc)?	☐ Yes	☐ No	If yes, explain _____
Have you ever engaged in any activity that has put you at risk of getting AIDS?	☐ Yes	☐ No	If yes, explain _____
Do you wish to be tested for AIDS?	☐ Yes	☐ No	If yes, explain _____
Have you ever worked with chemicals, paints, asbestos or other hazardous material?	☐ Yes	☐ No	If yes, explain _____
Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, punched, bruised) by your partner?	☐ Yes	☐ No	
Do you ever feel afraid of your partner?	☐ Yes	☐ No	N/A
Do you have a 'living will'?	☐ Yes	☐ No	
Do you have a donor card?	☐ Yes	☐ No	
Are you currently using a method of birth control?	☐ Yes	☐ No	If yes, what method _____

IGNACIO CARRILLO-NUNEZ MD
NEURODIAGNOSTIC CENTER
18111 Brookhurst St. #6200
Fountain Valley Ca 92708

Phone: (714) 378-5516 Fax: (714) 378-5517
Phone: (949) 397-6020 Fax: (949) 397-6022

AUTHORIZATION TO RELEASE INFORMATION

Last Name:_____ First Name:_____ M.I. :_____

Address: _____

Telephone:_____ DOB:_____ S.S.#:_____

I hereby authorize: _____
_____
_____

To release medical information from my medical record to:

IGNACIO CARRILLO-NUNEZ MD
NEURODIAGNOSTIC CENTER
18111 Brookhurst St. #6200
Fountain Valley Ca 92708

For the purposes of review/examination, I further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitation as indicated below:

_____ Complete Medical Records

_____ Specific Information _____

Reason for request: _____

This release will automatically expire in one year from the date signed. I understand that I may revoke this request at any time.

Signed: _____ Date: _____

Witness: _____ Date: _____