Northland Neurology & Myology, PA Patient Registration Form

Patient Demographics

Today's Date: _____ SSN: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Apartment Number: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Permission to leave detailed message (initial): _____ Sex: Male ☐ Female ☐ Other ☐

Martial Status: Child* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Employer Name: _____ Employer Phone: _____

If retired, date of retirement: _____

In Case of Emergency Notify:

Name: _____ Phone Number: _____

Relationship:_____

I give Northland Neurology permission to discuss billing or scheduling with the following party:

Name:_____ Effective dates: _____ to _____

Referral Information

Referred to us by: _____ Primary Care Physician: _____

Insurance Information

Insurance Card Provided at Check-in: Yes ☐ I do not have an insurance card ☐

Insurance Type: Commercial ☐ Medicare ☐ Medicare Advantage ☐ Medical Assistance ☐

Self Pay** (No Insurance) ☐ Work Comp or Auto Accident*** ☐

Primary Insurance	**Secondary Insurance**
Insurance Name: _____	Insurance Name:_____
Subscriber ID: _____	Subscriber ID:_____
Group Number: _____	Group Number: _____

*****Work Comp/Auto Accident Patients - REQUIRED**

Insurance Name: _____ Adjustor Name:_____

Claim Number: _____ Date of Injury: _____

****Self Pay Patients - REQUIRED**

A credit card authorization form and payment agreement must be signed prior to service.

Credit Card Number: _____ CVV/CVC: _____

Expiration Date: _____ Zip Code: _____

***If patient is a minor, or insurance is through a spouse, the following is REQUIRED**

Name of Parent/Spouse: _____

Parent/Spouse Date of Birth: _____

Parent/Spouse Social Security Number: _____

1000 E 1st Street, Suite 105
Duluth, MN 55805

Fax: 218-722-0600
Phone: 218-722-1122

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: _____

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Patient Medical History

Do you use tobacco: Yes -	Current Every Day Smoker ☐ Current Some Day Smoker ☐
No -	Former Smoker ☐ Never Smoker ☐ Smokeless Tobacco ☐
Family History	Allergies ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Strokes ☐ Hypertension ☐ Other:
Infectious Diseases:	Gonorrhea ☐ HIV/AIDS ☐ Hepatitis B ☐ Hepatitis C ☐ TB ☐ Other:
Surgeries and year completed:	

Provide a brief reason for your visit: _____

_____

Provide your current height and weight: _____(ft/inches) _____lbs.

Review of Symptoms

Cardiovascular
__ **None**
__ Ankles swell
__ Chest pain
__ Heart problems
__ Hypertension
__ Skipping/irregular heart beat

Head and Neck
__ **None**
__ Double vision
__ Failing vision
__ Headaches
__ Pain in ears
__ Persistent neck rigidity
__ Ringing in ears
__ See "floating lights"
__ Severe hearing loss

Musculoskeletal
__ **None**
__ Back pain
__ Joint/muscle problem
__ Physically handicapped/limited
__ Shoulder pain

Neuropsychological
__ **None**
__ 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
__ **None**
__ Have chronic cough
__ Have night sweats
__ Sit up to breathe easier
__ Spit up blood
__ Wheezing

Stomach and Intestines
__ **None**
__ 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
__ **None**
__ Any blood in urine
__ Any leakage of urine
__ Any retention of urine
__ Frequent night urination
__ Frequent urination
__ Hard to start urinary flow
__ Scanty urination

Your average alcohol consumption per week:

_____ **drinks**

Other current medical issues/conditions:

_____

_____

_____

_____

_____

_____

_____

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Patient Prescription History

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.	**Medication Allergies, Sensitivities, & Intolerances** I have no known drug allergies ☐
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**
6.	**6.**
7.	**7.**
8.	**8.**
9.	**9.**
10.	**10.**
11.	**11.**
12.	**12.**
13.	**13.**
14.	**14.**
Write in additional medications if more room is necessary:	

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