Sunset Neurological Group
Your path to recovery

WELCOME TO SUNSET NEUROLOGICAL GROUP

PATIENT INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell #: _____

Social Security Number: _____ Sex: ◯ Female ◯ Male

Employer: _____ Work Phone # _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

If married, spouse's name: _____
Spouse's employer:_____

Do you have a living will? ◯ Yes ◯ No Do you have a power of attorney? ◯ Yes ◯ No
If yes, who? : _____

Emergency Contact: _____ Relationship: _____
Home#: (___) _____ Cell#: (___) _____ DOB:_____

Insurance Information

Primary Insurance	Secondary Insurance
Subscriber	Subscriber
Policy Number_____	Policy Number _____
Group Number_____	Group Number _____
Insured's DOB_____	Insured's DOB_____

Physician(s) Information

Referring Physician: _____ Phone#: _____
Primary Physician: _____ Phone#: _____
Other Physicians involved in your care: _____
_____
Pharmacy Name: _____ Phone#: _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name (Last, First):				○ M	○ F	DOB:
Marital Status:	◉ Single	○ Widowed	○ Married	○ Divorced		○ Separated
Previous or referring doctor:				Date of last physical exam:		

PERSONAL HEALTH HISTORY		
Childhood illness: ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and Dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, mumps, Rubella*
List any medical problems that other doctors have diagnosed:		

List of past surgeries:

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	◯Yes	◯No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUETIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTAL

Exercise	◉ Sedentary (No exercise)				
	◯ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	◯ Occasional vigorous exercise (i.e., work or recreation, less than 4x/weeks for 30min.)				
	◯ Regular vigorous exercise (i.e., work or recreation, 4x/weeks for 30min.)				
Diet	Are you dieting?			◯ Yes	◯ No
	If yes, are you on a physician prescribed medical diet?			◯ Yes	◯ No
	# of meals you eat in an average day?				
	Rank salt intake	◯ High	◯ Medium	◯ Low	
	Rank fat intake	◯ High	◯ Medium	◯ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			◯ Yes	◯ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			◯ Yes	◯ No
	Have you considered stopping?			◯ Yes	◯ No
	Have you experienced blackouts?			◯ Yes	◯ No
	Are you prone to “binge” drinking?			◯ Yes	◯ No
	Do you drive after drinking?			◯ Yes	◯ No
Tobacco	Do you use tobacco?			◯ Yes	◯ No
	☐ Cigarettes- packs /days	☐ Chew-#/day	☐ Pipe-#/day	☐ Cigars-#day	
	# of years			Or year quit: _____	
Drugs	Do you currently use recreational or street drugs?			◯ Yes	◯ No
	Have you ever given yourself street drugs with a needle?			◯ Yes	◯ No
	Are you sexually active?			◯ Yes	◯ No
	If yes, are you trying for a pregnancy?			◯ Yes	◯ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			◯ Yes	◯ No

	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness may include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	○ Yes	○ No
Personal safety	Do you live alone?	○ Yes	○ No
	Do you have frequent falls?	○ Yes	○ No
	Do you have vision or hearing loss?	○ Yes	○ No
	Do you have and advance directive or living will?	○ Yes	○ No
	Would you like information on the preparation of these?	○ Yes	○ No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	○ Yes	○ No

FAMILY HEALTH HISTORY

FAMILY	AGE	SIGNIFICANT HEALTH PROBLEMS	FAMILY	AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children		○ M ○ F
Mother					○ M ○ F
Sibling/s		○ M ○ F			○ M ○ F
		○ M ○ F			○ M ○ F
		○ M ○ F	Grandmother *maternal*		
		○ M ○ F	Grandfather *Maternal*		
		○ M ○ F	Grandmother *Paternal*		
		○ M ○ F	Grandfather *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	○ Yes	○ No
Do you feel depressed?	○ Yes	○ No
Do you panic when stressed?	○ Yes	○ No
Do you have problems with eating o your appetite?	○ Yes	○ No
Do you cry frequently?	○ Yes	○ No
Have you ever attempted suicide?	○ Yes	○ No
Have you ever seriously thought about hurting yourself?	○ Yes	○ No
Do you have trouble sleeping?	○ Yes	○ No
Have you ever been to a counselor?	○ Yes	○ No

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, or discharge?	O Yes	O No
Number of pregnancies _____ Number of live birth/s _____		
Are you currently pregnant or breastfeeding?	O Yes	O No
Have you had a D&C, hysterectomy, or Cesarean?	O Yes	O No
Any urinary tract, bladder, or kidney infections within the last year?	O Yes	O No
Any blood in your urine?	O Yes	O No
Any problems with control of urination?	O Yes	O No
Any hot flashes or sweating at night?	O Yes	O No
Do you have menstrual tension, painful bloating, irritability, or other symptoms at or around time of period?	O Yes	O No
Experienced any recent breast tenderness, lumps, or nipple discharge?	O Yes	O No
Date of last pap smear and rectal exam?	O Yes	O No

MEN ONLY		
Do you usually get up to urinate during the night?	O Yes	O No
If yes, # of times ____		
Do you feel pain or burning with urination?	O Yes	O No
Any blood in your urine?	O Yes	O No
Do you feel a burning discharge from penis?	O Yes	O No
Has the force of your urination decreased?	O Yes	O No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	O Yes	O No
Do you have any problems emptying your bladder completely?	O Yes	O No
Any difficulty with erection or ejaculation?	O Yes	O No
Any testicle pain or swelling?	O Yes	O No
Date of last prostate and rectal exam? Date: _____	O Yes	O No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain:

☐ Skin	☐ Chest/Heart	Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	Other pain/discomfort:
☐ Lungs	☐ Circulation	

FINANCIAL RESPONSIBILITY FORM

Thank you for choosing: Sunset Neurological Group Inc. as your diagnostic company. We strive to give you the best possible care. In order to serve this purpose, it is important that you understand the process of reimbursement. Please read the Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE:

We attempt to verify that your coverage is valid at the time of the visit. However, verification of eligibility and coverage is not guarantee of payment and all claims are subject to review according to guidelines of each individual policy. It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitation, as well as, authorization requirements. This information can be obtained by contacting your insurance carrier.

- If you have any changes in your insurance coverage you must notify us.

CO-PAYMENTS, CO-INSURANCES AND DEDUCTILES:

Co-payment and co-insurances are your responsibility. Understand that you will be expected to pay your co-payment each and every date of service. You are also responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. You are responsible for finding out all information about your deductibles & copays prior to you appointment with our office.

RELEASE OF INFORMATION:

The physician(s) may disclose all or part of the patient record to any person or corporation that is or may be liable under a contract to the physician (S), or to the patient, or to a family member or employer of the patient, for all part of the physician (s) charges, including, but not limited to, insurance companies, workers compensation carries, welfare funds, or the patient employer.

Name: _____

Signature: _____

Date: _____

HIPPA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPPA) provide safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is available in the office.

What this is all about:

Specially, there are rules and restrictions on who may see of the notified of our Protected Health Information (PHI). These restrictions do not include the abnormal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goals of providing you with quality professional service and care. Additional information is available from U.S Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that administrative matters related to your cares are handled appropriately. This specifically includes the sharing information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.
2. It is the policy is this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by technology that you might find valuable or informative, insurance items pertaining to your clinical care such as : laboratory and pathology results, diagnostic results, among other.
3. You understand and agree to inspections of the office and review of the documents which may include PHI by the government agencies or insurance payers in normal performance duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or doctor.
5. We agree to provide patient with the access to their medical records in accordance with state federal laws.
6. We may change, add, delete or modify any of these provisions to the better serve the needs of both the patient and the practice.
7. You have the right to request restrictions in the use of your protected health information and to the request change in certain policies used within office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Signature **Date**