Sunset Neurological Group
Your path to recovery

BIENVENIDO A SUNSET NEUROLOGICAL GROUP

REGISTRO DEL PACIENTE

Fecha: _____

Nombre del Paciente: _____ Fecha de Nacimiento: _____

Dirección: _____

de Teléfono de Casa: _____ # de Celular: _____

de Seguro Social: _____ Sexo: ◯Femenino ◯Masculino

Nombre de Empleador: _____

de Teléfono del Trabajo _____

Estado Civil: ◯ Soltero(a) ◯ Casado(a) ◯ Divorciado(a) ◯ Viudo(a)

Si es casado, Nombre del esposo(a): _____
Empleador del cónyuge: _____

Contacto de Emergencia: _____ Relación: _____
#Casa: _____ #Celular: _____ #Trabajo: _____

Información del Seguro

Seguro Primario	Seguro Secundario
Suscriptor de la Póliza	Suscriptor de la Póliza
Numero de la Póliza	Numero de la Póliza
Numero de Grupo	Numero de Grupo
Dia de Nacimiento del suscriptor	Dia de Nacimiento del suscriptor

Información del Doctor Primario

Nombre del Doctor que lo refirió: _____ # de Teléfono: _____
Doctor Primario: _____ # de Teléfono _____
Otro Doctor: _____
_____
Nombre de la Farmacia: _____ # de Teléfono: _____

HISTORIAL CLINICO

Toda la información en este cuestionario es estrictamente confidencial y será parte de su historial clínico.

Nombre del Paciente:	◯M	◯F	Fecha de Nacimiento: _____

Estado Civil:	◯Soltero	◯ Viudo	◯ Casado	◯ Divorciado	◯ Separado

Nombre de su Doctor:	Dia del Último Examen Físico:

Historia Medica

Por favor indique si alguna vez ha tenido las siguientes condiciones:

- ☐Diabetes
- ☐Enfermedad de los riñones
- ☐Embolia
- ☐Tuberculosis
- ☐Hipertensión
- ☐Hepatitis
- ☐Asma
- ☐Tiroides
- ☐Infarto
- ☐Endisema
- ☐Convulsión
- ☐Depresión
- ☐Arteriopatía Coronaria
- ☐Problemas Cardiaco
- ☐Problemas Visuales
- ☐Cáncer

Lista cualquier otro problema medico que le han diagnosticado:

Lista de cirugías pasadas:

Año	Razón	Hospital

Otras hospitalizaciones

Año	Razón	Hospital

Alguna vez ha tenido una transfusión de sangre?	◯Si	◯No

Lista de Medicamentos que toma, incluyendo vitaminas e inhalantes:		
Nombre	Cantidad	Frecuencia
Alergias a Medicamentos:		
Nombre del Medicamento:	Reacción:	

HABITOS DE SALUD Y SEGURIDAD PERSONAL

Alcohol	Toma usted alcohol?	○ Si	○ No
Tabaco	Fuma o usa algún producto de Tabaco?	○ Si	○ No
	Si usted fuma cual es el # de cigarros al día?		
Drogas	Ha usado otras drogas regularmente?	○ Si	○ No

HISTORIAL FAMILIAR

	EDAD	PROBLEMAS MEDICOS		EDAD	PROBLEMAS MEDICOS
Padre			Hijos		○ M ○ F
Madre					○ M ○ F
Hermanos		○ M ○ F			○ M ○ F
		○ M ○ F			○ M ○ F
		○ M ○ F	Abuela *maternal*		
		○ M ○ F	Abuelo *Maternal*		
		○ M ○ F	Abuela *Paternal*		
		○ M ○ F	Abuelo *Paternal*		

SALUD MENTAL		
¿El estrés es un problema importante para usted?	○ Si	○ No
¿Se siente usted deprimido?	○ Si	○ No
¿Entra en pánico cuando esta estresado?	○ Si	○ No
¿Tiene problemas para comer o de apetito?	○ Si	○ No
¿Llora con frecuencia?	○ Si	○ No
¿Alguna vez ha intentado suicidarse?	○ Si	○ No
¿Alguna vez ha pensado en lastimarse seriamente?	○ Si	○ No
¿Tiene problemas durmiendo?	○ Si	○ No
¿Alguna vez ha ido a un consejero?	○ Si	○ No

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**