Neurology First & Coresight Neuro-Ophthalmology
PATIENT REGISTRATION

Name: _____ **Date of Birth**: _____

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

Social Security #: _____ **Phone**: _____ **Alt. Phone**: _____

Emergency Contact: _____**Relationship to Emergency** _____**Phone** _____

Marital Status: _____ **Employment Status (Please circle)**: Employed Unemployed Retired Student

Race: Native American Caucasian African American Asian Hispanic Other (please specify) _____

PHONE NUMBER **that we can text for confirming appointments and test results:** _____

PRIMARY CARE PHYSICIAN: _____**Primary Care Physician phone**_____

PHARMACY DETAILS

Name of pharmacy:_____**Pharmacy Phone**: _____

Pharmacy address:_____ **City**: _____ **State**:_____ **Zip**:_____

INSURANCE DETAILS

Primary Insurance Name: _____ **Name of Insured**: _____

Secondary Insurance name: _____

MISSED APPOINTMENT POLICY

Unless canceled at least 48 hours in advance, our policy is to charge a MISSED/NO SHOW FEE of **$40.00**.

Your insurance company will not pay this fee.

_____ **Initial that you have read the Missed Appointment Policy.**

RELEASE OF MEDICAL INFORMATION STATEMENT

Please provide the names of individuals with whom we can share your medical information. If the name is not listed on this form, we will not disclose any information.

I hereby give my consent to CORESIGHT and/or the physician, practitioner's employee by CORESIGHT to provide requested information from my medical record to third party payers and/or other health care providers deemed necessary.

_____ **Initial that you have read and agree to the Release of Medical Information Statement.**

ASSIGNMENT OF BENEFITS

I understand that I am responsible for all charges on my account regardless of insurance. I authorize payment of any benefits due from my insurance company to CORESIGHT for services rendered to myself and/or my dependents.

Signature: **X** _____ **Date**: _____

Printed Name: _____ **Relationship to Patient**: _____

Name: _____ **Date of Birth**: _____

SOCIAL HISTORY

Tobacco Use: _____ **Type / Amount per Day:** _____

Alcohol Usage: _____ **Type / Amount per Day**: _____

Recreational Drug Usage: _____ **Type / Amount per Day**: _____

Occupation: _____ **Do you drive?**: _____

PAST MEDICAL HISTORY

Have you ever had…?

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
Anemia			Heart Disease (specify what type)			Lupus		
Asthma			High Cholesterol			Mental Illness (depression/anxiety/bipolar)		
Cancer (specify what type)			Hypertension			Pulmonary Embolism		
COPD			Hypothyroidism			Rheumatoid Arthritis		
Diabetes Type I			Hyperthyroidism			Stroke		
Diabetes Type II			Lung Disease (specify what type)			Seizure		
Other						Traumatic Brain Injury		

Details: _____

_____

PAST OCULAR HISTORY (Coresight Neuro-ophthalmology Patients Only)

Have you ever had…?

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
Cataracts (which eye?)			Dry Eyes			Glaucoma		
Contact use			Eye Trauma (which eye?)			Macular Degeneration		
Other:								

Details: _____

_____

Name: _____ **Date of Birth:** _____

FAMILY MEDICAL HISTORY

Please list those who have poor health or are deceased.

Relationship (Please specify maternal/paternal)	Age	Medical Conditions / Cause of Death

SURGICAL AND HOSPITALIZATION HISTORY

Please list approximate dates and reasons for surgeries/hospitalizations.

_____

_____

_____

MEDICATIONS

Please list current medications

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ALLERGIES

Please list any allergies

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_____

Name: _____ **Date of Birth:** _____

REVIEW OF SYSTEMS

Have you recently had. . .?

CONSTITUTIONAL	Yes	No	CARDIAC	Yes	No	HEMATOLOGY/IMMUNOLOGY	Yes	No
Fever			Chest Pain			Pallor		
HEAD	**Yes**	**No**	Palpitations			Spontaneous or easy bruising and/or bleeding		
Headaches			Syncope (Fainting)			Lymph Node pain or swelling		
Dizziness			**RESPIRATORY**	**Yes**	**No**	Recurrent Infections		
EYES	**Yes**	**No**	Cough			**JOINTS**	**Yes**	**No**
Diplopia (Double vision)			Sputum Production			Arthralgia (pain in joints)		
Scotoma (Partial vision loss or blind spot)			Hemoptysis (Coughing blood)			Arthritis (inflammation in the joint)		
Eye discharge			Dyspnea (Shortness of breath)					
Eye pain			**GASTROINTESTINAL**	**Yes**	**No**	**NEUROLOGIC**	**Yes**	**No**
Light sensitivity			Dysphagia (Difficulty swallowing)			Seizures		
EAR	**Yes**	**No**	Hematemesis (Vomiting blood)			Loss of Consciousness		
Ear pain			**GENITO-URINARY**	**Yes**	**No**	Gait imbalance		
Tinnitus (Ringing in ears)			Flank Pain (pain on the side)			Difficulty with speech		
Vertigo (Spinning sensation)			Dysuria (Painful urination)			Numbness/Tingling		
Ear discharge			Hematuria (Blood in urine)			Weakness		
DERMATOLOGIC	**Yes**	**No**	Difficulty initiating urination			Tremors		
Rash			**ENDOCRINE**	**Yes**	**NO**			
Photosensitivity (sun allergy)			Polydipsia (Excessive thirst)					
MOUTH	**Yes**	**No**	Polyuria (Excessive urination)					
Bleeding			Hyperactivity					
Ulceration (open sore)			Galactorrhea (Excessive or inappropriate milk secretion from breast)					
Glossodynia (Burning sensation in mouth)			Gynecomastia (Enlarged breast in men)					
Xerostomia (Dry mouth)								
THROAT	**Yes**	**No**						
Sore Throat								
Hoarseness								