NEUROLOGY
ADULT & PEDIATRIC EPILEPSY
GENERAL NEUROLOGY

Malone-Davis Neurology
7730 W. Cheyenne Ave, Ste 107
Las Vegas, NV 89129
725.221-1568

Date:

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES			
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	**ADDRESS**		
CITY, STATE	**ZIP**	**HOME PHONE**	**CELL PHONE**
PATIENT DATE OF BIRTH	**PATIENT SSN**	**SEX** ❑ **Male** ❑ **Female**	**MARITAL STATUS** ❑ **Single** ❑ **Married** ❑ **Other**_____
Email:	**Ethnicity:** ❑ **Hispanic or Latino** ❑ **Not Hispanic or Latino** ❑ **Refused to Report**	**Language:** ❑ **English** ❑ **Spanish** ❑ **Other, please list below**	**Race:** ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Pacific Islander ❑ Other Race ❑ Unreported/Refused to Report
PATIENT EMPLOYER NAME	**PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)**	**EMPLOYER PHONE**	

INSURED/RESPONSIBLE PARTY INFORMATION	RELATION TO PATIENT: ❑spouse ❑parent ❑guardian			
NAME (FIRST -- LAST -- MIDDLE INITIAL)	**ADDRESS (if different from patient)**			
HOME PHONE	**WORK PHONE**	**SSN**	**BIRTH DATE**	**EMPLOYER**

INSURANCE INFORMATION			
PRIMARY INSURANCE NAME	**ADDRESS (STREET - CITY - STATE - ZIP)**		**PHONE**
GROUP NUMBER	**SUBSCRIBER/ID NUMBER**	**EMPLOYER**	**EMPLOYER PHONE**
SECONDARY INSURANCE NAME	**ADDRESS (STREET - CITY - STATE - ZIP)**		**PHONE**
GROUP NUMBER	**SUBSCRIBER/ID NUMBER**	**EMPLOYER**	**EMPLOYER PHONE**

PRIMARY DOCTOR/FAMILY DOCTOR	**REFFERING DOCTOR**	
IN CASE OF EMERGENCY CONTACT:	**RELATIONSHIP**	**PHONE NUMBER**
Does the above mentioned emergency contact have permission to discuss your protected health information: Yes_____ No _____		

HIPAA and RELEASE OF INFORMATION

ASSIGNMENT AND RELEASE INSURANCE

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. I understand that the physician has a right to change their privacy practices and that I may obtain any revised notices at the clinic. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

PATIENT FINANCIAL POLICY

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies explained in the Malone-Davis Neurology, PLLC Patient Financial Policy Form. There is a detailed form available upon request.

AUTHORIZATION TO RELEASE INFORMATION TO:

Name(s)	**ADDRESS**		
CITY, STATE	**ZIP**	**PHONE**	**FAX**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER** **DATE:**		

Release the following information:

❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

RELEASE OF INFORMATION

I understand that:

- Once Malone-Davis Neurology discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

PERMISSION TO ACCESS EXTERNAL PRESCRIPTION INFORMATION

I understand that:

- By signing this form, I give this facility permission to access my prescription history from outside facilities

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**	
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**	

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Patient Name_____ DOB: _____

Chief Complaint_____

Other Symptoms_____

PAST MEDICAL HISTORY Please check all that apply:

High Blood Pressure	Yes☐	No☐	Kidney Disease	Yes☐	No☐
High Cholesterol	Yes☐	No☐	Liver Disease	Yes☐	No☐
Cardiovascular Disease	Yes☐	No☐	Stomach/Intestinal Disease	Yes☐	No☐
Stroke or TIA	Yes☐	No☐	Diabetes	Yes☐	No☐
Cancer	Yes☐	No☐	If yes, where: _____		

Other: _____

REVIEW OF SYTEMS Please check all that apply:

General:
- ☐ Weight gain/loss
- ☐ Fatigue
- ☐ Fever/Chills

Ear
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Fullness/Pressure in ear

Mouth/Throat/Neck
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bleeding gums

Nose
- ☐ Congestion
- ☐ Runny nose
- ☐ Nosebleed

Skin
- ☐ Rash
- ☐ Skin changes
- ☐ Hair changes
- ☐ Nail changes

Eyes
- ☐ Vision changes
- ☐ Vision loss
- ☐ Watery/Dry eyes
- ☐ Eye pain

Head
- ☐ Headaches
- ☐ Head trauma
- ☐ Head surgery

Endocrine
- ☐ Insomnia
- ☐ Change in appetite
- ☐ Heat/Cold intolerance
- ☐ Increased urination

Cardiac
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Palpitations

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Muscle spasms

Gastrointestinal
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation

Urinary
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Frequent urination

Respiratory
- ☐ Shortness of breath
- ☐ Apneas
- ☐ Wheezing

Vascular
- ☐ Pain in limb
- ☐ Swelling
- ☐ Blood clots

Hematologic
- ☐ Bleeding
- ☐ Bruises easily
- ☐ Anemia

Psychiatric
- ☐ Memory changes
- ☐ Mood changes
- ☐ Anxiety/Depression

Patient Name: _____ DOB: _____

SOCIAL HISTORY

Have you eve used drugs: Heroin, Cocaine, Barbiturates, or other controlled substances ☐ Yes ☐ No

HAVE YOU EVER SMOKED? ☐Yes ☐No If yes, how long? _____ How much? _____

Are you still smoking? _____

DO YOU DRINK CAFFEINATED BEVERAGES? ☐Yes ☐ No If yes, how many cups? _____

☐ Coffee ☐ Soda ☐ Tea ☐ Other: _____

Alcohol: ☐ Yes ☐No How much daily? _____

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	CAUSE	MED PROBLEMS
GRANDMOTHER				
GRAND FATHER				
FATHER				
MOTHER				
SIBLINGS				

HOSPITALIZATION: Please list down the most recent hospital visit(s)

_____

SURGERIES (Please list surgeries and dates, or other significant procedure/ medical problems, etc.)

_____

_____

_____

Patient Name: _____ DOB: _____

ALLERGIES (Medication or other): _____

CURRENT MEDICATIONS:

DRUG NAME	DOSAGE	HOW OFTEN	STARTED	STOPPED	REASON FOR TAKING

PHARMACY INFORMATION:

PHARMACY NAME: _____PHONE: _____

ADDRESS/LOCATION: _____