

# Phoenix Neurology and Sleep Medicine

Phone: (623) 535-0050 Fax: (623) 535-9520



## Phoenix Neurology & Sleep Medicine

Goodyear Office:  
2940 N Litchfield Rd  
Goodyear, AZ 85395

Deer Valley Office:  
2925 W Rose Garden Lane  
Phoenix, AZ 85027

Central Office:  
300 E Osborn Rd Ste # 200  
Phoenix, AZ 85012

Phone (623) 535-0050

Fax (623) 535-9520

### **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

(Original to be maintained in patient's permanent medical record)

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name if signed on behalf of the Patient

\_\_\_\_\_  
Relationship to the Patient

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## Patient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SSN \_\_\_\_\_  
(Last) (First) (MI)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work \_\_\_\_\_

Sex  Male Age \_\_\_\_\_ DOB \_\_\_\_\_  Married  Single  Divorced  
 Female  Widowed  Other

Email Address \_\_\_\_\_

Employed?  No  Yes Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

## Primary Insurance

Insurance Name: \_\_\_\_\_ Insured's Name \_\_\_\_\_

Insured's DOB \_\_\_\_\_ Insured's SSN \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Policy or ID # \_\_\_\_\_ Group # \_\_\_\_\_

## Secondary Insurance

Insurance Name: \_\_\_\_\_ Insured's Name \_\_\_\_\_

Insured's DOB \_\_\_\_\_ Insured's SSN \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Policy or ID # \_\_\_\_\_ Group # \_\_\_\_\_

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## Contact Information:

I may be contacted in the following manner:

OK to leave message with detailed information \_\_\_ Home \_\_\_ Work \_\_\_ Cell \_\_\_ NO

OK to leave call back number only \_\_\_ Home \_\_\_ Work \_\_\_ Cell \_\_\_ NO

OK to send mail to \_\_\_ Home \_\_\_ Work \_\_\_ NO

Those who may receive information included in my medical records:

\_\_\_ Spouse Name \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_ Other Name \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_ Other Name \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_  
(Patient's Signature) (Date)

## Assignment and Release

I certify that I, and/or my dependents, have insurance and assign directly to Phoenix Neurology and Sleep Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Phoenix Neurology and Sleep Medicine may use my healthcare information and may disclose such information to the above named insurance company/s and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
(Signature of the Patient/Parent/Guardian) (Date)

\_\_\_\_\_  
(Signature of the Patient/Parent/Guardian) (Date)

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## Front Office and Appointment Guidelines

- All co-payments and account balances are due at the time services are rendered, unless other arrangements have been made. We accept cash, check, Visa, MasterCard, American Express and Discover.
- Inform the front office receptionist of any change in demographics or insurance. Failure to do so may lead to an account balance.
- If you have an insurance plan that requires a paper referral or authorization number, it is your responsibility to make sure the referral has been completed by your primary care physician and is in our office for your scheduled appointment time. If we do not have a referral or authorization your appointment can be rescheduled.
- Give at least a 24 hour notice when cancelling or rescheduling an appointment, so we may use that appointment slot for another patient.
- If you are late for your appointment the doctor will be unable to see you.
- **There is a \$50 fee for No Show appointments and same day cancellations.**
- **There is a \$25 fee for ALL NSF Returned Checks.**
- **There is a \$200 fee for No Show Sleep Test appointments or same day cancellations.**
- Please allow 24 to 48 hours for your prescription to be filled. PRESCRIPTIONS WILL NOT BE REFILLED OVER THE WEEKEND.
- Please allow 7 to 14 business days for your tests or procedures to be scheduled (e.g. MRIs, CTs, Physical Therapy, etc.). Either our office or the contracted facility will contact you to schedule the appointment.

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(Patient Signature and Date)

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Your Name \_\_\_\_\_ Today's Date \_\_\_\_\_

**Chief Complaint:** Please explain why you have come here, including problems, date of onset, sudden or gradual onset, frequency, duration, nature and factors which bring on, worsen or improve this complaint. Please describe intermittent problems/spells as best as you can:

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**Past Medical History** (Please mark all problem referring to the following functions.)

General Problems:

\_\_\_ Energy \_\_\_ Weight Loss \_\_\_ Fever \_\_\_ Sweats \_\_\_ Chills \_\_\_ Fatigue \_\_\_ Stamina \_\_\_ Appetite

Neurological Problems:

\_\_\_ Headache/Migraine \_\_\_ Blurred Vision \_\_\_ Double Vision \_\_\_ Hearing Loss \_\_\_ Ringing in Ears

\_\_\_ Speech(slurred/loss) \_\_\_ Swallowing,Chewing \_\_\_ Head Trauma \_\_\_ Concussion \_\_\_ Blackouts

\_\_\_ Seizures \_\_\_ Dizziness \_\_\_ Vertigo(spinning) \_\_\_ Incontinence \_\_\_ Weakness \_\_\_ Coordination

\_\_\_ Gait \_\_\_ Balance \_\_\_ Involuntary Movements \_\_\_ Insomnia \_\_\_ Obstructive Sleep Apnea

\_\_\_ Restless Legs \_\_\_ Stroke \_\_\_ Confusion \_\_\_ Memory Loss \_\_\_ Neck Pain \_\_\_ Low Back Pain

\_\_\_ Numbness/Tingling \_\_\_ TIA Other \_\_\_\_\_

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## Medical Problems:

Diabetes  High Blood Pressure  TB  Heart Disease  Heart Attack  Asthma  
 COPD  Breathing Problems  Thyroid  Bleeding  Clotting  Anemia  Colitis  
 Irritable Bowel  Fibromyalgia  Lupus  Rheumatoid Arthritis  Kidney Disease  
 Lyme Disease  Cancer  Sleep  Snoring  Frequent Awakening  
 Difficulty Falling Asleep    Other \_\_\_\_\_

## Past Surgical History (Please list all surgeries you have had.)

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## Current Medications and Dosages

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## Drug Allergies (Please list allergies to any medications and the reaction you have.)

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## **Review of Systems**

### **General**

Weight Loss or Gain  Fatigue  Fever or Chills  Trouble Sleeping

### **Skin**

None  Rashes  Dryness

### **Ears**

None  Decreased hearing  Ringing in ears(tinnitus)  Earache

### **Eyes**

None  Vision  Pain  Blurry or double vision

### **Respiratory**

None  Cough  Shortness of breath

### **Cardiovascular**

None  Chest pain or discomfort  Palpitations  Swelling (edema)

### **Gastrointestinal**

None  Swallowing difficulties  Change in appetite  Nausea  Diarrhea  Constipation

### **Urinary**

None  Frequency  Urgency  Incontinence

### **Musculoskeletal**

None  Muscle or joint pain  Stiffness  Back pain  Redness of joints  Swelling

### **Neurologic**

None  Dizziness/Vertigo  Fainting  Seizures  Weakness  Numbness/Tingling   
Tremor

### **Endocrine**

None  Head or cold intolerance  Sweating

### **Psychiatric**

None  Anxiety  Depression  Memory Loss  Stress  Hallucinations/delusions

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## Family History

\_\_\_ Alzheimer's \_\_\_ Stroke/Heart Attack \_\_\_ Epilepsy \_\_\_ Migraines/Headaches \_\_\_ Neuropathy

Other \_\_\_\_\_

## Social History

Smoking: Y/N PPD: \_\_\_\_\_ Alcohol: Y/N Amount: \_\_\_\_\_

Caffeine: Y/N Amount: \_\_\_\_\_ Illicit Drugs: \_\_\_\_\_

## Any Additional Information:

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What pharmacy should we list in our system where all your prescriptions will go to? (Please list name, address and phone number. If you do not have this information please list the major cross streets.)

\_\_\_\_\_  
(Pharmacy Name)

\_\_\_\_\_  
(Pharmacy Address)

\_\_\_\_\_  
(Phone #)

\_\_\_\_\_  
(Pharmacy Cross Streets)



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## Patient Additional Information Needed

\*Please note we are required by the government to ask these questions for demographic purposes\*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_ Account #: \_\_\_\_\_

Please choose a Race:

- Asian
- American Indian / Alaska Native
- Black / African American
- Native Hawaiian / Other Pacific Islander
- White
- Declined

Please choose an Ethnicity:

- Hispanic / Latino
- Non-Hispanic / Latino
- Declined

What languages do you speak?

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How did you hear about this office:

- My Insurance
- IMS Marathon
- Friend / Family Member
- Quest Dex / Yellow Pages
- Online Search
- Other, Please Specify: \_\_\_\_\_

Can DCR contact you about studies you may qualify for?

- Yes
- No

\*THIS INFORMATION IS REQUIRED FOR STATISTICAL ANALYSIS. FROM THE AGENCIES OF EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT AND BUDGET, OFFICE OF INFORMATION AND REGULATORY AFFAIRS, DUE TO REVISIONS TO THE STANDARDS FOR THE CLASSIFICATION OF FEDERAL DATA ON RACE AND ETHNICITY (10/30/1997). THE REVISED STANDARDS WILL HAVE 5 MINIMUM CATEGORIES FOR DATA ON RACE (AMERICAN INDIAN OR ALASKA NATIVE, ASIAN, BLACK OR AFRICAN AMERICAN, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, AND WHITE) AND 2 CATEGORIES FOR DATA ON ETHNICITY (HISPANIC, NOT HISPANIC). OMB IS ANNOUNCING ITS DECISION CONCERNING THE REVISION OF STATISTICAL POLICY DIRECTIVE NO. 15, RACE AND ETHNIC STANDARDS OF FEDERAL STATISTICS AND ADMINISTRATIVE REPORTING.

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Signature below is acknowledgement that you have read and understand this Privacy Notice.

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

## Release of Information

I \_\_\_\_\_ hereby authorization PNSM to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

I authorize PNSM to contact me at:

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

May we leave a message on machine? \_\_\_ Yes \_\_\_ No

Cell #: \_\_\_\_\_ Alt #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



**Phoenix Neurology  
& Sleep Medicine**  
Where patients & their providers are family.

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**Goodyear**  
2940 N. Litchfield Road, Goodyear AZ 85395

**Glendale**  
20100 N 51<sup>st</sup> Ave F640, Glendale, AZ 85308

**Down Town**  
300 E. Osborn Road Ste 200, Phoenix AZ 85012

**Scottsdale**  
\*\* Coming Soon \*\*

**Flagstaff**  
710 N Beaver St Bldg 3, Flagstaff, AZ 86001

**Sun City**  
10503 W Thunderbird Blvd # 202, Sun City, AZ 85351

**Authorization to Release / Receive Medical Records**

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_ SSN: \_\_\_\_\_

(City)

(State)

(Zip Code)

I hereby authorize Phoenix Neurology & Sleep PLLC to receive and/or release medical record information concerning the above named patient to:

**Requesting Records From:**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Address \_\_\_\_\_

(City)

(State)

(Zip Code)

**Releasing Records To:**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Address \_\_\_\_\_

(City)

(State)

(Zip Code)

- Copy of all medical records of the last two years of treatment received
- Copy of medical records covering dates from \_\_\_\_\_ to \_\_\_\_\_
- Copy of \_\_\_\_\_ results.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\*\*\*\*\*FOR OFFICE USE ONLY\*\*\*\*\*

Printed Records on \_\_\_\_\_. Initials \_\_\_\_\_

Given to \_\_\_\_\_ on \_\_\_\_\_. Initials \_\_\_\_\_

Faxed on \_\_\_\_\_. Initials \_\_\_\_\_