PACIFIC CENTER FOR NEUROLOGICAL DISEASE, INC.

CMA The Center For Memory and Aging
A Project of Pacific Center for Neurological Disease, Inc

Offices:
15644 Pomerado Road,
Suite 401
Poway, CA 92064

New Patient Intake Form

I. Demographic Information

Date: _____

Name: _____ Date of Birth: _____ Age: _____ SSN: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Marital Status: _____ Sex: _____

Driver License:_____ Spouse Name: _____

II. Point of Contact/Responsible Party other than Patient

Name: _____ Relationship to Patient: _____

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

Phone: _____ Cell: _____ Email: _____

Allowed access to medical information? Yes No

III. Insurance Information

Primary Insurance (circle or write in): Aetna Anthem Blue Cross Blue Shield Community Health Group Cigna Health Net Medicare Sharp/Arch Tricare United Health Care Other:_____

Subscriber Name: _____ Relationship to Patient: _____

ID # _____ Group # _____ Group Name: _____ Co-pay:_____

Secondary Insurance (circle or write in): Aetna Anthem Blue Cross Blue Shield Community Health Group Cigna Health Net Medicare Sharp/Arch Tricare United Health Care Other:_____

Subscriber Name: _____ Relationship to Patient: _____

ID # _____ Group # _____ Group Name: _____ Co-pay:_____

IV. Care Information – please list complete name and address of physicians (VERY IMPORTANT)

Primary Care Physician:_____

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

Phone: _____ Fax: _____ Email: _____

Referring Physician (if different from PCP): _____ Specialty: _____

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

Phone: _____ Fax: _____ Email: _____

Pharmacy: _____ Address: _____

Phone: _____ Fax: _____City: _____ State: _____ Zip: _____

V. Reason for visit – Chief Complaint (History of Present Illness)

Please describe the major problem that brings you in today to see a Neurologist:

_____

_____

If this problem is the result of an accident, when did the accident occur? _____

VI. Pain Assessment

Do you experience pain as part of your daily life? (circle one) Yes No

If yes, please describe the location(s), onset, duration, and characteristics of your pain:

_____

_____

If yes, on a scale of 1 to 10 (0 = no pain, 10 = the worst pain), how would you rate your pain?

1 2 3 4 5 6 7 8 9 10

What makes your pain better? (Circle all that apply) Medications Bending Laying Sitting Standing

Walking Changing positions Stretching Nothing

Comment: _____

VII. Social History

Occupation: _____Retirement year:_____ Number of children: _____

Handedness: Are you (circle one): Left Handed Right Handed Ambidextrous

Hobbies:_____

Do you smoke cigarettes? _____ If so, how many packs a day? _____

At what age did you start? _____If applicable, at what age did you stop?_____

Do you drink alcohol? _____ If yes, how much daily? _____

At what age did you start? _____ If applicable, at what age did you stop?_____

Do you use recreational drugs? _____ Type _____

Do you exercise regularly? (Circle one) Yes No How frequently?_____

Females: Are you, or could you be pregnant? (Circle one) Yes No

Planning on getting pregnant? (Circle one) Yes No within the next… 3 months 6 months Year

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VIII. Family History Do you have a **FAMILY MEMBER** affected with:

Condition	Yes	No	type / relative	Condition	Yes	No	type / relative
Arthritis	☐	☐		Asthma	☐	☐	
Aneurysm	☐	☐		Brain Tumor	☐	☐	
Cancer	☐	☐		Muscle Disease	☐	☐	
Seizures or Epilepsy	☐	☐		Dementia	☐	☐	
				Diabetes	☐	☐	
Parkinson's	☐	☐		Hypertension	☐	☐	
M.S	☐	☐		Neuropathy	☐	☐	
Lung disease	☐	☐		Migraine/Headaches	☐	☐	
Thyroid dis.	☐	☐		Psychiatric disorder	☐	☐	
Kidney disease	☐	☐		Other Neuro cond.	☐	☐	

Other conditions:_____

_____

IX. Medical History Do you currently, or have you had a problem with:

Constitutional:	***Circle One***		***Endocrine***:	***Circle One***	
Fever/chills	Yes	No	Diabetes	Yes	No
Weight loss >10 lbs	Yes	No	Thyroid disease	Yes	No
Excessive fatigue	Yes	No	Excessive thirst/urination	Yes	No
History of Falls	Yes	No	Low blood sugar	Yes	No
Insomnia	Yes	No	***Genitourinary:***		
Eyes:			Urinary tract infections	Yes	No
Wear glasses	Yes	No	Painful urination	Yes	No
Infections/redness	Yes	No	Blood in your urine	Yes	No
Injuries	Yes	No	Difficult start or stop of stream	Yes	No
Glaucoma	Yes	No	Incontinence	Yes	No
Cataracts	Yes	No	Kidney stones	Yes	No
Loss of vision	Yes	No	Discharge (vaginal/penile)	Yes	No
Ear, Nose, Throat& Mouth:			***Musculoskeletal:***		
Wear hearing aid(s)	Yes	No	Broken bones	Yes	No
Hearing loss	Yes	No	Arm or leg weakness	Yes	No
Ear pain/infections	Yes	No	Arm or leg pain	Yes	No
Ringing in ears	Yes	No	Joint pain, swelling, stiffness	Yes	No
Nose bleeds	Yes	No	Arthritis	Yes	No
Nasal congestion/drainage	Yes	No	Difficulty walking	Yes	No
Double or blurred vision	Yes	No	Neck/Back/Hip pain	Yes	No
Loss or inability to smell	Yes	No	***Integumentary:***		
Skin disease (ulcers, cancer)	Yes	No	Hives	Yes	No
Difficulty swallowing	Yes	No	Rash	Yes	No
Balance (vertigo, spinning, etc.)	Yes	No	Unusual moles	Yes	No

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IV. Medical History (continued):

Cardiovascular:			***Neurological:***		
Chest pain or angina	Yes	No	Fainting spells or "black outs"	Yes	No
High blood pressure	Yes	No	Headaches	Yes	No
Irregular pulse/murmur	Yes	No	Seizures	Yes	No
Heart attack (MI)	Yes	No	Problems with memory	Yes	No
High cholesterol	Yes	No	Disorientation	Yes	No
Swelling in hands or feet	Yes	No	Difficulty with speech	Yes	No
Awake from sleep unable to	Yes	No	Inability to concentrate	Yes	No
Breath (PND)			Dizziness	Yes	No
Respiratory:			Numbness/tingling	Yes	No
Asthma	Yes	No	Loss of sensation	Yes	No
Emphysema	Yes	No	Difficulty with balance	Yes	No
Shortness of breath	Yes	No	***Psychiatric:***		
Pneumonia	Yes	No	Anxiety	Yes	No
Bloody sputum	Yes	No	Depression	Yes	No
Bronchitis (chronic)	Yes	No	Mood swings	Yes	No
Apnea	Yes	No	Substance abuse	Yes	No
Gastrointestinal:			***Hemotologic/Lymphatic:***		
Nausea	Yes	No	Anemia	Yes	No
Vomiting	Yes	No	Hemophilia	Yes	No
Bloody stool	Yes	No	Blood transfusion	Yes	No
Liver disease/jaundice	Yes	No	Persistent swollen glands/node	Yes	No
Bloating	Yes	No	Hepatitis	Yes	No
Abdominal pain	Yes	No	HIV	Yes	No
Change in bowel habits	Yes	No	***Allergic/Immunologic:***		
Ulcers or gastritis	Yes	No	Food, Inhalant (nasal) allergies	Yes	No
Loss of appetite	Yes	No	Autoimmune disease (i.e.,lupus)	Yes	No

X. Surgical History - Please list all operations you have had

Operation:	**Date:**	**Operation:**	**Date:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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XI. Medication

Please LIST all ALLERGIES and sensitivities (e.g. medications, foods, latex, iodine, etc.)

_____

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking any "blood thinning" medications? ☐ Yes – indicate below ☐ No

☐ Aspirin or aspirin-containing medication ☐ Anti-inflammatory medication ☐ Plavix ☐ Coumadin

☐ Fish Oil ☐ Other: _____

The information on this form is accurate to the best of my knowledge and I was offered HIPAA guidelines:

_____ _____

Patient Signature Date

Cancellation and No Show Policy

Our goal is to meet the needs of our patients and we will make every effort to efficiently schedule your appointments. In return, it is your responsibility to make every effort to keep your schedule appointments and arrive promptly at the time designated to you. We do realize that unanticipated events may occur from time to time and prevent you from keeping your appointment. In fairness and consideration to other patients, we hereby request that you notify our office immediately when you realize you will not be able to keep your appointment.

If you need to cancel or reschedule your appointment, you must do so at least 24 hours before your scheduled appointment to avoid paying $50 for each missed scheduled appointment. Please be aware that this fee is not covered by medical insurance and is the patient responsibility due at the next appointment visit along with any co-payment or fee-for-service.

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Authorization to Release Medical Information

By signing below, you (or your designee) hereby authorize us to use, obtain or disclose information about yourself that is protected under federal law, for the sole purpose and duration of time you are under our care.

You may refuse or revoke this authorization. Please be advised however that any revocation will be effective only to the extent we have not already taken action in reliance to your authorization.

I authorize reports of my evaluation, treatments and any follow up evaluations to be sent or discussed with my referring/primary/consulting physician(s), as well as any other healthcare provider/professional associated with my care. I understand that the information obtained will become part of my medical chart and may be revealed to the claims examiner/adjuster responsible for my claim or to my insurance company as applicable.

Patient Name: _____

DOB: _____

SS#: _____

I have read and understand the authorization above.

I also permit a copy/fax of this form to serve as an original signature of authorization. **(_____) Initial**

Patient Signature: _____ Date:_____

Parent or Designee Signature:_____ Date:_____

TO BE RELEASED:

☐ Billing ☐ Chart Notes ☐ Entire Chart

☐ Lab Results ☐ EEG / EMG/ NCV Report ☐ Imaging Results

☐ Other _____

TO BE RELEASED TO: _____

_____

_____

I **DO NOT WANT i**nformation disclosed to: _____

_____