Dr. Rebecca Jones, MD
Dr. Leslie Zuniga, MS, MD
Dr. Evelyn Sikora, Psy.D.

CNS Center for Neurology and Spine | Multiple Sclerosis Center of Arizona

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

AGE: _____ SEX: ◯ MALE ◯ FEMALE ◯ I DO NOT WISH TO DISCLOSE

MARTIAL STATUS: _____ SOCIAL SECURITY #: _____

RACE:

BLACK/AFRICAN AMERICAN WHITE ASIAN NATIVE AMERICAN

NATIVE HAWAIIN/PACIFIC ISLANDER MIDDLE EASTERN OR NORTH AFRICAN OTHER

ETHNICITY:

HISPANIC/LATINO NOT HISPANIC/LATINO

HOME ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

STUDENT: ◯ YES ◯ NO ◯ FULL TIME ◯ PART TIME

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

HOW DID YOU HEAR ABOUT US? PHYSICIAN FRIEND/FAMILY MEMBER WEBSITE INSURANCE OTHER

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ CELL PHONE: _____

ADDRESS: _____

OTHER CONTACT INFORMATION

PARENT OR SPOUSE'S NAME: _____

PARENT OR SPOUSE'S DOB: _____ PARENT OR SPOUSE'S SS#: _____

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PATIENT HISTORY

PATIENT NAME: _____ AGE: _____

MAIN COMPLAINT & SYMPTOMS:

WHEN DID THIS PROBLEM FIRST START? (PLEASE FILL IN DATE): _____

DESCRIBE THE FREQUENCY AND DURATION OF SYMPTOMS:

PLEASE DESCRIBE PREVIOUS TREATMENTS YOU'VE TRIED AND HOW EFFECTIVE THEY WERE:

HAVE YOU CONSULTED OTHER DOCTORS FOR THIS PROBLEM BEFORE? ◯ **YES** ◯ **NO**

IF YES, PLEASE LIST NAME(S): _____

HAVE YOU BEEN TREATED BY A PHYSICAL OR OCCUPATIONAL THERAPIST? ◯ **YES** ◯ **NO**

IF YES, BY WHOM? _____

PLEASE CHECK ALL SYMPTOMS THAT YOU HAVE:

1. **HEMATOLOGY/LYMPHATIC:** ○ EASY BLEEDING ○ EASY BRUISING ○ RECURRENT INFECTIONS

2. **CONSTITUTIONAL:** ○ FATIGUE ○ FEVER ○ WEIGHT GAIN ○ CHILLS

3. **EYES:** ○ VISION LOSS ○ BLURRED VISION ○ EYE PAIN ○ DOUBLE VISION

4. **EARS, NOSE, THROAT:** ○ JAW PAIN ○ JAW POPPING/CLICKING ○ HEARING LOSS ○ EAR PAIN ○ SNORING ○ RINGING IN EARS

5. **RESPIRATORY:** ○ COUGH ○ WHEEZING

6. **CARDIOVASCULAR:** ○ LIGHTHEADNESS ○ PASSING OUT ○ CHEST PAIN/PRESSURE ○ IRREGULAR HEART ○ PALPITATIONS

7. **GASTROINTESTINAL:** ○ ABDOMINAL PAIN ○ DIARRHEA ○ VOMITTING ○ NAUSEA ○ CONSTIPATION

8. **GENITOURINARY:** ○ KIDNEY STONES ○ URINARY RETENTION/URGENCY ○ URINARY INCONTINENCE

9. **MUSCULOSKELTAL:** ○ NECK PAIN ○ MID OR LOWER BACK PAIN ○ SORE MUSCLES ○ CRAMPS

10. **SKIN:** ○ HAIR LOSS ○ NEW RASHES ○ SKIN ULCERATIONS ○ HIVES

11. **NEUROLOGIC:** ○ BALANCE DIFFICULTY ○ COORDINATION ○ DIZZINESS ○ HEADACHE ○ MEMORY LOSS ○ SEIZURES ○ TINGLING/NUMBNESS ○ TREMOR

12. **PSYCHIATRIC:** ○ PANIC ATTACKS ○ DEPRESSION ○ ANXIETY ○ VISUAL OR AUDITORY HALLUCINATIONS

PATIENT MEDICAL HISTORY: (ALL ILLNESSES, ACUTE OR CHRONIC)

NAME	STRENGTH/DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

SURGICAL HISTORY: (PLEASE LIST ALL EVEN MINOR ONES SUCH AS TONSILLECTOMY)

NAME OF SURGERY	YEAR
1.	
2.	
3.	
4.	
5.	

ALLERGIES: (I.E LATEX, PENICILLIAN, DYES, IV CONTRAST ETC.)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

MEDICATIONS: (INCLUDING SUPPLEMENTS, VITAMINS, AND HERBS)

NAME	STRENGTH/DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PERSONAL AND SOCIAL HISTORY:

ARE YOU CURRENTLY EMPLOYED? YES NO **OCCUPATION**: _____

IF DISABLED:

DATE OF DISABILITY BEGAN: _____

CAUSE OF DISABILITY: _____

HIGHEST LEVEL OF EDUCATION: _____

HOW MANY STEPS TO THE ENTRANCE OF YOUR HOME? _____

HOW MANY FLOORS IN YOUR HOME? _____

HAVE YOU EVER SMOKED? YES NO **DO YOU CURRENTLY SMOKE?** YES NO

(IF YOU SMOKE) HOW MANY YEARS? _____ HOW MANY PER DAY? _____

DO YOU DRINK ALCOHOL? YES NO **WEEKLY AMOUNT**?_____

DO YOU DRINK CAFFEINE? YES NO **WEEKLY AMOUNT**?_____

HAVE YOU USED RECREATIONAL DRUGS WITHIN THE PAST YEAR? YES NO

IF YES, WHAT?_____

FAMILY HISTORY: PLEASE CHECK ANY THAT APPLY FOR IMMEDIATE FAMILY

○ STOKE ○ TIA ○ SEIZURES/EPILESPY ○ CANCER ○ DIABETES

○ HEART DISEASE ○ HEADACHE/MIGRAINE ○ MULTIPLE SCLEROSIS ○ HYPERTENSION

○ HIGH CHOLESTROL ○ MEMORY LOSS/COGNITIVE IMPAIRMENT

OTHER NEUROLOGICAL DIEASE (PLEASE EXPLAIN BELOW):

FAMILY MEMBER INFORMATION: PLEASE FILL OUT HEALTH INFORMATION BELOW

	AGE	LIVING	DECEASED	MEDICAL ISSUES
FATHER:	_____	○	○	_____
MOTHER:	_____	○	○	_____
SISTER(S):	_____	○	○	_____
BROTHER(S):	_____	○	○	_____
DAUGHTER(S):	_____	○	○	_____
SON(S):	_____	○	○	_____

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NAME: _____ DOB: _____ DATE: _____

SIGNATURE: _____

PAYMENT POLICY

ADDRESS CORRESPONDENCE TO:
3805 E. BELL ROAD, #2400
PHOENIX, AZ 85032
PHONE: 602-482-2116
FAX: 602-482-9563

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PATIENT NAME: _____ DOB: _____ DATE: _____

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE DIRECT PAYMENTS TO:
CENTER FOR NEUROLOGY AND SPINE

I understand I am financially responsible for any co-payments, deductibles, coinsurance and all other charges which are considered to not be a covered benefit by my insurance company. I understand that verification of coverage is not a guarantee of benefits. Actual plan coverage and benefit payments are determined when a claim is received.
I understand that I am financially responsible for all charges if it is determined that the insurance information I have provided is no longer in effect. Please inform staff immediately of any and all insurance changes.

INITIAL: _____

PAYMENTS:

I understand that payment is expected at time of service for copays, co-insurance, and/or deductibles. CNS accepts cash, checks, Visa, Master Card, and American Express as forms of payment. If your check is returned for insufficient funds, a $35 returned check fee will be applied to your outstanding balance.

INITIAL: _____

DELINQUENT ACCOUNTS:
I understand delinquent accounts will be reported to a collection agency following CNS normal collection procedure of four (4) patient statements being mailed. If an account is reported to a collection agency, then a fee of 30% will be added to your outstanding balance. Please inform the billing department if your payment will be late arriving or you need to set up a payment plan.

INITIAL: _____

FORMS:
Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., there will be a fee of $50. Payment of this charge is expected at time of completion.

INITIAL: _____

APPOINTMENT NO-SHOW:
I understand there is a charge for not canceling/rescheduling an appointment within 24 hours. Regular office visit is $50 while procedures such as EEG, AEEG, EMG, Botox, and Neuro Psychometric testing is $100. As these appointment times could have been given to another patient who needs medical care. We understand unusual circumstances might arise so please contact our office as soon as possible if needing to cancel or reschedule.

SIGNED: _____ **DATE:** _____

RELEASE OF INFORMATION:
I hereby authorize release of medical information to my referring physician and/or to any other physicians who have been or may become involved in my care. I also authorize release of information that may be necessary in processing any insurance claims.

SIGNED: _____ **DATE:** _____

COMMUNICATION AUTHORIZATION

PATIENT NAME: _____ DOB: _____

AT WHAT PHONE NUMBER(S) MAY WE CONTACT YOU? MAY WE LEAVE A MESSAGE?

_____ ◯ YES ◯ NO

_____ ◯ YES ◯ NO

DO YOU HAVE A POWER OF ATTORNEY OR MEDICAL POWER OF ATTORNEY (POA/MPOA)?

◯ YES (PLEASE PROVIDE A COPY TO THE OFFICE) ◯ NO

DO YOU AUTHORIZE CNS TO COMMUNICATE WITH YOUR PHARMACY? ◯ YES ◯ NO

LOCAL PHARMACY: _____ PHONE: _____

PHARMACY ADDRESS: _____ FAX: _____

MAIL ORDER PHARMACY: _____ PHONE: _____

DO YOU AUTHORIZE CNS TO COMMUNICATE WITH YOU VIA EMAIL? ◯ YES ◯ NO

EMAIL ADDRESS: _____

PATIENT SIGNATURE: _____ DATE: _____

HIPAA AUTHORIZATION

IS THERE ANYONE OTHER THAN YOURSELF THAT YOU AUTHORIZE CNS TO SPEAK WITH ON BEHALF OF YOUR MEDICAL CARE? IF SO, PLEASE LIST BELOW:

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES ESTABLISHED THE HIPAA PRIVACY REGULATION IN DECEMBER 2000, WHICH THEN BECAME EFFECTIVE ON APRIL 14, 2003. THE PRIVACY RULE PROVIDES FOR THE PROTECTION AND PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AND GUARDS AGAINST MISUSE OF SUCH INFORMATION.

SIGNATURE: _____

DATE: _____

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