BEND NEUROLOGICAL associates LLC

PATIENT INFORMATION

NAME: _____
LAST SUFFIX FIRST PREFERRED M.I.

MAILING ADDRESS: _____
CITY S TATE ZIP

HOME NUMBER: _____

CELL NUMBER: _____

WORK NUMBER: _____

DOB: _____ **SEX:** _____ **SSN:** _____

MARITAL STATUS: □ Single □ Married □ Divorced □ Widowed □ Partner □ _____

RESPONSIBLE PARTY/GUARANTOR (IF PATIENT IS A MINOR): □ *Self/Patient*

NAME: _____
LAST FIRST M.I.

DOB: _____ **PHONE NUMBER:** _____ **RELATION:** _____

EMERGENCY CONTACT:

NAME: _____
LAST FIRST M.I.

PHONE NUMBER: _____ **RELATION:** _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

RACE:	**ETHNICITY:**	**LANGUAGE:**
□ American Indian or Alaska Native	□ Hispanic or Latino	□ English
□ Black/African American	□ Not Hispanic or Latino	□ Spanish
□ Native Hawaiian/Other Pacific Islander	□ Declined to specify	□American Sign Language
□ Asian □ Hispanic		□ Other
□ White □ Other Race		
□ Declined to specify		

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PHARMACY INFORMATION:

LOCAL PHARMACY	MAIL ORDER PHARMACY
NAME:	NAME:
ADDRESS:	ADDRESS: **N/A**

*PLEASE ***SPECIFY GENERAL LOCATION*** IF ADDRESS IS UNKNOWN AS THERE ARE SEVERAL LOCATIONS FOR MANY LOCAL PHARMACYS*

COMMUNICATION:

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine's/voice mail/text message.

Email Address: _____

Please check all boxes that give Bend Neurological Associates, LLC permission to use for your communications:

You may leave a message/voice mail	☐ YES	☐ NO
You may contact me by telephone	☐ YES	☐ NO
You may contact me by text message (SMS)	☐ YES	☐ NO
You may contact me through email	☐ YES	☐ NO

RELEASE OF INFORMATION: ☐ PLEASE CHECK IF SAME AS EMERGENCY CONTACT

Please list any persons you would like to have access to your billing, appointment or health information, such as your ***spouse, caretaker or other family member, ect***. We will ask for additional consent prior to releasing information related to psychiatric services and/or HIV test results.

NAME	RELATIONSHIP	PHONE NUMBER
1.		
2.		
3.		

CIRCLE OF CARE:

Please ***list any physician or healthcare providers*** who coordinate in your care that need to receive chart notes from each visit (Examples: Primary Care Physician, Cardiologist, Dermatologist, Oncologist…..)

NAME	SPECIALITY
1.	
2.	
3.	

****BNA STAFF**-Please make sure this is updated in **both** sections of chart (info and circle of care)***

CONSENT TO SHARE INFORMATION WITH HEALTH INFORMATION EXCHANGE AND OTHER COVERED ENTITIES:

Bend Neurological Associates, LLC (BNA) understands that you may receive medical care from our healthcare professionals and from healthcare professionals outside of our network, including non-BNA providers using our electronic medical record platform to support their treatment activities. To ensure that your treating providers have complete and accurate medical information about you, BNA participates in a Health Information Exchange (HIE) and transmits information to the HIE and your non-BNA providers through automated processes. This information sharing allows your treating providers to coordinate and provide quality medical care, particularly during emergencies.

BNA is committed to protecting your privacy and confidentiality and uses secure means to share your information.

Please be advised that this consent form only applies to automated data transfers to the HIE and your non-BNA providers regarding the information listed below. All health information not included below may be shared in accordance with our Notice of Privacy Practices.

You understand the nature of your release and hereby consent to and acknowledge the following:

- By signing this form, your treating providers outside of BNA may request, view, print, and store your health information listed below with secure means. If you are physically unable to sign, you may consent orally if witnessed by two (2) staff members.
- Health information that may be shared may include the following: the evaluation, diagnosis, and/or treatment of
    - O Drug and/or alcohol abuse and/or dependence
    - O Mental health
    - O HIV/AIDS
- This consent does not expire; however, you can revoke it and opt out of information sharing at any time. To opt out, you must request an Opt Out of Information Sharing with Health Information Exchange and other Covered Entities form from your provider's office. Any of your electronic health information listed above that is disclosed before you opt out cannot be taken back.
- Your treatment will not be affected in any way, whether you sign or do not sign this form. You are not required to sign this form to receive treatment.
- A disclosure statement will accompany your shared electronic health information listed above, as required by state and/or federal law.

Signature of Patient/Responsible Party Date

Relationship to Patient

BEND NEUROLOGICAL associates LLC

PATIENT ACKNOWLEDGMENT OF POLICIES:

By signing below, I acknowledge the following Bend Neurological Associates policies and that I have a right to receive a copy upon request.

(Please initial each policy)

General Information & Policies, which includes:

(INTIALS)

-Appointment & Cancellation Policy

Cancellations should be made at least 24 hours prior to your scheduled appointment time. If you cancel or fail to show for appointments, we reserve the right not to reschedule your appointment.

-Forms & Endorsement Policy

If this is an urgent matter, please refer to your Primary Care. Bend Neurological Associates will require pre-payment on any and all forms or endorsements that require the attention of a healthcare provider.

External Prescription History

(INTIALS)

Bend Neurological Associates, LLC uses an Electronic Medical Record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection which improves the timely and accurate transmission of your medication information.

Financial Policy & Assignment of Payment

(INTIALS)

The patient is expected to update Bend Neurological Associates regarding any insurance changes and to present an insurance card at each visit.

Privacy Policy

(INTIALS)

It is the policy of Bend Neurological Associates to follow all HIPAA privacy rules.

Signature of Patient/Responsible Party Date

Relationship to Patient

****BNA STAFF**-Please make sure Signature date, Consent portion & AD are updated in chart***

BEND NEUROLOGICAL associates LLC

PATIENT MEDICAL HISTORY:

LAST: _____ **FIRST:** _____ **MI:** _____

DOB: _____ **HEIGHT:** _____ **WEIGHT:** _____

In your own words, *BRIEFLY* describe your chief complaint: _____

Have you had any previous **diagnostic studies**?
(Such as MRI, MRA, CT…ect.) ☐ No ☐ Yes - If yes, what type: _____

Have you had any **labs** drawn recently? ☐ No ☐ Yes - If yes, where: _____

Recently involved in an accident or trauma? ☐ No ☐ Yes - If yes, where: _____

What other doctors have you seen for your current problem? _____

ALLERGIES: ☐**None** ☐Penicillin ☐Sulfa ☐Aspirin ☐Nickel ☐Codeine ☐Chromate ☐Latex ☐Iodine ☐Pollen
☐Other Allergies Not Listed: _____

MEDICATIONS: ☐**None** List medications (including over the counter medications, such as vitamins, Tylenol, etc.)

Drug	Dosage/Strength	Frequency	Notes

SURGERY/HOSPITALIZATIONS: ☐ **None**

☐ Heart Bypass ☐ Gall Bladder ☐ Cesarean Section ☐ Appendectomy ☐ Angioplasty ☐Hernia
☐ Pacemaker ☐ Hysterectomy ☐ Carotid ☐ Back Surgery ☐ Other: _____

MEDICAL HISTORY: Handedness: ☐Right ☐Left ☐Ambidextrous

☐ Angina ☐ Cancer: _____ ☐ Hepatitis ☐ Seizures
☐ Asthma ☐ Glaucoma ☐ High Blood Pressure ☐ Stroke
☐ Bladder problems ☐ High Cholesterol ☐ Kidney Problems ☐ Vision Loss
☐ Blood clots ☐ Heart Trouble ☐ Migraines
☐ Other: _____

SOCIAL HISTORY: If former or current:

Substance Abuse: ☐ Never ☐ Former ☐ Current Type and Frequency: _____

Tobacco: (13 & older) ☐ Never ☐ Former ☐ Current How many: Packs/day _____ Years _____ Year quit _____

Alcohol Consumption: ☐ None ☐ Social ☐Moderate ☐Heavy How often: _____ Weekly OR Monthly (CIRCLE)

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FAMILY HISTORY:

☐ *Unknown* Paternal=Father Maternal=Mother

	Father	Daughter(s)	Son(s)	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Siblings
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neuropathy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐	☐	☐	☐
MS	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐

REVIEW OF SYSTEMS:

(Please check any of the following that apply to you)

General
Weight loss O Yes
Weight gain O Yes
Fever O Yes
Fatigue O Yes
Rash O Yes

Psychiatric
Depression O Yes
Suicidal Thoughts O Yes
Anxiety O Yes

Sleep
Sleepiness O Yes
Insomnia O Yes
Snoring O Yes
Restless Leg O Yes

HEENT
Headaches O Yes
Lightheadness O Yes
Vertigo O Yes
Hearing Loss O Yes
Ringing in ear O Yes
Visual Loss O Yes
Fading Vision O Yes
Double Vision O Yes

Gastrointestinal
Nausea O Yes
Vomiting O Yes
Abdominal pain O Yes
Blood in stool O Yes

Cardiac
Chest Pressure/pain O Yes
Palpitations O Yes
Loss of consciousness O Yes

Neurologic
Numbness O Yes
Weakness O Yes
Poor coordination O Yes
Imbalance O Yes
Speech Difficulties O Yes
Trouble swallowing O Yes
Spells/Blanking out O Yes
Seizures O Yes
Memory Loss O Yes
Tremor O Yes
Hallucinations O Yes

Respiratory
Shortness of breath O Yes
Chest pain O Yes
COPD O Yes

Extremities
Leg swelling O Yes

Rheumatologic
Red/hot/tender joints O Yes
Muscle cramps O Yes
Neck pain O Yes
Back pain O Yes
Muscle Pain O Yes

Genitourinary
Incontinence O Yes
Kidney Stones O Yes
Pregnancy O Yes
Sexual Dysfunction O Yes

Infectious Disease
Exposure to:
AIDS O Yes
Unusual Illness O Yes
Tick bites O Yes
Other: