ROCKY MOUNTAIN NEUROLOGY

Amelia Scott Barrett, M.D.
Daniel Kitei, D.O., M.A.
Katie Coerver, M.D., Ph.D.

## PATIENT DEMOGRAPHICS

| **First Name:** | MI | **Last Name:** | **Date of Birth:** |
|---|---|---|---|
| | | | |

| Nickname: | Sex: | SSN: | Race / Ethnicity: | E-mail address: |
|---|---|---|---|---|
| | | | | |

| **Address:** | **City:** | **State:** | **Zip:** |
|---|---|---|---|
| | | | |

| **Home Phone:** | **Cell Phone:** | **Work Phone:** |
|---|---|---|
| | | |

| Preferred phone number: | ☐ Home | ☐ Work | ☐ Cell | Marital Status: | Employer: |
|---|---|---|---|---|---|
| Ok to leave detailed msg: | ☐ Home | ☐ Work | ☐ Cell | | |

| **Primary Care Physician:** | **Referring Physician:** |
|---|---|
| | |

*Please provide first **and** last name. Please <u>also</u> provide phone & fax if they are not a local Dr., *

## INSURANCE POLICYHOLDER (IF OTHER THAN SELF)

| ☐ Primary Ins | ☐ Secondary Ins | **Name:** | Relationship: | **DOB:** | SSN: |
|---|---|---|---|---|---|
| ☐ Primary Ins | ☐ Secondary Ins | **Name:** | Relationship: | **DOB:** | SSN: |

## IN CASE OF EMERGENCY

| Name: | Relationship: | Address: | Home phone no.: ( ) | Work/cell phone no.: ( ) |
|---|---|---|---|---|
| | | | | |

## PRIVACY

**WHO CAN WE SHARE YOUR MEDICAL INFORMATION WITH?** (Family members, etc.- Please give **full names.** You may want to provide a contact phone number if they are different than your emergency contact above.)

*Please provide documentation if Power of Attorney applies*

## PHARMACY

| Name: | Address (*or major cross street <u>and</u> city*) | Phone no.: ( ) | Fax no.: ( ) |
|---|---|---|---|
| | | | |

**<u>PATIENT RESPONSIBILITIES</u>**

- I hereby authorize assignment of benefits to be paid directly to Dr. Barrett, Dr. Kitei or Dr. Coerver.
- I understand that it is my sole responsibility to check with my insurance company regarding coverage & cost for any procedures and/or office visits. I am responsible for obtaining all referrals and insurance authorizations.
- I authorize Dr. Barrett, Dr. Kitei or Dr. Coerver to provide protected health information to my insurance company for billing purposes.
- I understand that regardless of any insurance coverage or other potential co-guarantor or responsible party, I am accepting full financial responsibility for payment of all charges for services provide to me, my spouse or dependents by this practice. I agree that if my employer, insurance carrier or plan sponsor denies payment to all of or any portion of my claim, I will be financially responsible for all outstanding charges. I agree to pay a late fee of $25 if my account should become over 60 days past due. In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 33% of the outstanding balance or a minimum of $40.00 (whichever is greater) to offset in part the collection agency's fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.
- TCPA Acknowledgment - I authorize this office, its agents and assignees to contact me by telephone, text/SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.
- A fee of $50.00 may be assessed if I do not show up for a follow-up appointment or if I cancel without 24 hours notice. A fee of $150 may be charged if I do not show up for a testing appointment. The implementation of this policy is at the discretion of the office and circumstances are always considered.
- I give permission for the office to access my external medication history.
- I acknowledge review of HIPAA notice, and have received a copy if I requested it.

_____ _____

**PATIENT (**or POWER OF ATTORNEY/GUARDIAN*) **SIGNATURE** DATE

***<u>If signed by a Legal Guardian or Power of Attorney</u>***

Legal Guardian/POA Name: _____ Relationship to patient: _____

*By providing your signature above, you attest that you have the legal right to sign for the patient.

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**NAME:** _____ **DATE OF BIRTH:** ____/____/____

*What symptoms are you being seen for today?* _____
_____

Height: _____ ft _____ in | Weight: _____ lbs.

**MEDICATIONS**

| *Name* | *Strength (mg etc.)* | *Frequency (how often?)* | *Condition this medication is for* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Are you allergic to any medications?** *YES NO* **If so, which ones?** _____

| ADDITIONAL MEDICAL CONDITIONS | DATE (IF APPLICABLE) |
|---|---|
| | |
| | |

| MAJOR SURGERIES | DATE (IF APPLICABLE) |
|---|---|
| | |
| | |

**FAMILY HISTORY**

| | |
|---|---|
| **Father** ☐ Alive ☐ Deceased ☐Unk. | **Medical conditions:** |
| **Mother** ☐ Alive ☐ Deceased ☐Unk. | **Medical conditions:** |
| **Are there any other medical conditions that run in your family?** | |

*(Examples of medical conditions we're looking for: diabetes, hypertension, heart disease, stroke, mental illness, cancer etc.)*

**REVIEW OF SYSTEMS**

**(*Please circle all that applies*)**

**General:** weight loss, weight gain, fevers **ENT:** sinus infections, ear pain/fullness, dizziness, ringing in ears
**Eyes:** blurry vision, double vision, loss of vision **Psychiatric:** sadness/depression, anxiety, hallucinations
**Respiratory:** shortness of breath, wheezing, cough **Genitourinary:** frequent urination, impotence, painful urination
**Cardiovascular:** heart palpitations, passing out/blackouts, poor circulation **Skin:** rashes, birthmarks, skin growths
**Gastrointestinal:** burning in stomach, constipation, diarrhea **Musculoskeletal:** weakness, joint pain, joint swelling
**Neurologic:** headache, difficulty swallowing, tingling/burning, neck/back pain, slurred speech, tremors, memory problems, balance problems, muscle cramps, numbness

**ADDITIONAL QUESTIONS**

*(Please circle)*

Do you have an Advanced Directive? YES NO
*If so, have you assigned a decision maker? YES NO*
Have you received a flu shot? YES NO
Have you received the pneumonia vaccine? YES NO
Are you in pain today? YES NO
*If so, please rate your pain on a level of 1-10:* _____
Is your appointment today regarding a work or auto related injury? WORK AUTO N/A
*If so, what was the date of injury?* _____

**SOCIAL HISTORY**

**Are you a:**
☐ **Current smoker**
*If so, how much?* _____
*Date started:* _____
☐ **Former smoker**
*If so, date range:* _____-_____
☐ **Never smoker**

**Do you drink alcohol?**
☐ **Yes**
*If so, how often?* _____
☐ **No**

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