Print Form

Assistant Professor of Neurology
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Team Neurologist
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Florida Center for Headache & Neurology

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REGISTRATION FORM

(Please Print)

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name: First: Middle:			☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:		Work Number: ( )	Cell phone: ( )		
Chose clinic because/Referred to clinic by (please check one box):		☐ Dr.		☐ Insurance Plan	☐ Hospital	
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other		
Other family members seen here:						

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ☐ Yes ☐ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ☐ Yes ☐ No			

Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

Is this visit related to an accident case or lawsuit of any kind ☐ Yes ☐ No

If yes: Attorney's Name: Attorney's Phone Number:

Are you currently seeing a pain management doctor ☐ Yes ☐ No

If Yes: Physicians Name

Address:

Current Medications

Medication	Dose/Strength	Frequency

Do you currently or have you ever had any of the following

- ☐ Heart Attack
- ☐ Stroke
- ☐ Peripheral Vascular Dis.
- ☐ Restless Legs
- ☐ Blood Clots
- ☐ Chronic Neck Pain
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Heart Rhythm Problems
- ☐ Varicose Veins
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Vertigo
- ☐ Anemia
- ☐ Elevated Cholesterol
- ☐ Lupus
- ☐ Epilepsy or Convulsions
- ☐ Memory Problems
- ☐ Depression
- ☐ Anxiety
- ☐ Arthritis
- ☐ Osteo
- ☐ Rheumatoid
- ☐ Thyroid Problems
- ☐ Macular Degeneration
- ☐ Lung Disease
- ☐ Sleep Apnea
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Degenerative Disease of the Spine
- ☐ Diabetes
- ☐ Urinary Tract Problems
- ☐ Chronic Low Back Pain
- ☐ Cancer
- ☐ Headache
- ☐ Skin Disease
- ☐ Neuropathy
- ☐ Chronic Pain
- ☐ Peripheral Edema
- ☐ Trauma/Accidents
- ☐ Obesity
- ☐ IBS
- ☐ Fibromyalgia
- ☐ "Heartburn"
- ☐ Seasonal Allergies
- ☐ Insomnia
- ☐ Other_____

ALLERGIES (Foods, Medicines, Animals, Toxins) **Reaction:**

_____ _____
_____ _____
_____ _____

PERSONAL HABITS

Alcohol ❑ Yes ❑ No If yes how much?_____ # of Years?_____

Tobacco ❑ Yes ❑ No If yes how much?_____ # of Years?_____

FAMILY HISTORY:

☐ Premature Heart Disease / Heart Attack (Under Age 50)

☐ High Blood Pressure

☐ High Cholesterol

☐ Diabetes

☐ Obesity

☐ Cancer

Prior Surgeries	Date

IN CASE OF EMERGENCY	
Name of local friend or relative (not living at same address):	Relationship to patient:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature