



Assistant Professor of Neurology
Florida State University College of Medicine



Florida Center for Headache & Sports Neurology

REGISTRATION FORM (Please Print)

Today's date:			Primary Care Physician REQUIRED :			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Mis <input type="checkbox"/> S <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):			<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:						

INSURANCE / BILLING 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:			Employer phone no.: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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

- | | |
|---|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Peripheral Vascular Dis. | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Restless Legs | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Neck Pain | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Degenerative Disease of the Spine |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Rhythm Problems | <input type="checkbox"/> Urinary Tract Problems |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Chronic Low Back Pain |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Peripheral Edema |
| <input type="checkbox"/> Epilepsy or Convulsions | <input type="checkbox"/> Trauma/Accidents |
| <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Depression | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> "Heartburn" |
| <input type="checkbox"/> Osteo | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Rheumatoid | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> 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 and phone# of local friend or relative (not living at same address):	Relationship to patient:
<p><u>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 Florida Center for Headache & Neurology / F.X.Surgical, LLC or insurance company to release any information required to process my claims. I hereby also confirm that I have read the Office Policy Binder that was given to me at arrival time, and hereby agree to comply with its contents.</u></p>	
Patient/Guardian signature	