

Registration Form

Date: ____ / ____ / ____

Are you a new patient: Yes No

Physician Name: _____ Referring Physician: _____

PATIENT INFORMATION (Please Print)

Name: (First/Middle/Last) _____ D.O.B.: _____

Address: _____

City, State, Zip: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security #: _____ Patient Sex: M F

Marital Status: M S D W

Spouse Name: _____ D.O.B.: _____

Please circle:

Race: Alaskan Native American Indian Asian African American Hispanic or Latino Indian White

Language: Chinese English French German Italian Japanese Somali Spanish Vietnamese Other

Ethnicity: Hispanic or Latino Non Hispanic or Latino

Email Address: _____

Contact Preference: home# _____ cell# _____ day# _____

Guarantor Name: _____ D.O.B.: _____

Guarantor Address (if different): _____

City, State, Zip: _____

Insurance Provider: _____ Name of Insured: _____

Group Name: _____ Policy#: _____ Group#: _____

In Case of Emergency (Someone at different phone number)

Name: _____ Relationship: _____

Phone#: _____ Alternate#: _____

Patient Signature: _____ Date: _____

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Patient Authorization for Use and Disclosure of Protected Health Information

1. By signing this Authorization, I authorize **Advanced Neurology & Sleep** to disclose protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name: _____ Relationship: _____

Method of Communication: _____

Name: _____ Relationship: _____

Method of Communication: _____

2. May we contact you regarding your protected health information, health status, appointments, and test results?

Yes, you may contact me by email, my address is: _____

No, do not contact me by email for this purpose.

Yes, you may contact me by phone, my daytime phone numbers are:

(_____) _____ (_____) _____

Can we leave a message regarding your protected health information at the numbers you provided above? Yes No

No, do not contact me by phone for this purpose.

3. May we send you newsletters and other marketing information by email?

Yes, please use the following email address: _____

No, I do not want to be sent newsletters or other marketing information.

I understand that I do not have to sign this Authorization in order to receive treatment and revocation of any authorizations will not affect my ability to continue receiving treatment.

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any re-disclosures of my health information by a third party may no longer be protected under federal or state privacy laws.

I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, and sickle cell anemia or HIV infection.

I understand that this Authorization will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this Authorization to the address below or send an email to the address at the bottom of this Authorization. However, any disclosure that occurred prior to the date of the revocation will not be affected.

I understand that no protected health information (other than as outlined by the Health Insurance Portability and Accountability Act and in the Practice Notice of Privacy Practices, a copy of which I have received) can be released to anyone, including spouses, parents, other family members, significant others or friends without this Authorization.

Patient Signature: _____ Date: _____

Printed Patient Name: _____ DOB: _____

Signature of Patient Representative: _____ Date: _____

Printed Name of Patient Representative: _____ Relationship: _____

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Revised 10.8.2021

Patient Information

Louise Y. (Lucy) Ledbetter, MD, MBA
Laura J. Roberts, ACNP-BC | Amanda Goke, MSN, FNP-C

CONSENT FOR MEDICAL TREATMENT: I, the undersigned, hereby consent to any medical treatment rendered to me under the general and special instructions of the health care provider in charge. In the event an employee is accidentally exposed to my blood/bodily fluids, I hereby consent to the testing of my blood as deemed necessary by the health care provider. I also acknowledge that the health care provider can make no guarantee or warranty to any treatment or service rendered.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to **Advanced Neurology & Sleep** the insurance benefits due for any treatment of service provided. I understand that in billing the insurance company, a diagnosis may be used that is considered confidential information.

FINANCIAL AGREEMENT: I understand that payment for medical services in this office for my dependants or myself is due and payable at the time services are rendered unless other arrangements have been made. Services not covered by my insurance plan are my responsibility. It is my responsibility to understand my health insurance benefits and what is not covered.

DISCLOSURE OF MEDICAL INFORMATION: I authorize the practice to release my medical information for the purpose of providing, coordinating or managing health care and related services. I authorize the practice to disclose my medical information to obtain payment for services provided to me.

NOTICE OF PRIVACY PRACTICES: The privacy notice describes ways in which we may use and disclose medical information. The notice also describes my rights and legal obligations with regard to my medical information. My signature below acknowledges that I have been given a copy of **Advanced Neurology & Sleep's** privacy notice.

MEDICARE/TENNCARE/CHAMPUS PATIENTS: If I am a Medicare, TennCare or Champus patient, I certify that the information I provided when applying for payment under the Social Security Act is correct.

RETURN CHECK POLICY: I understand that I will be charged a \$25.00 fee for any returned checks.

Patient Name Printed: _____ Date: _____

Signature: _____ Date: _____

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New Patient Form

Louise Y. (Lucy) Ledbetter, MD, MBA
Laura J. Roberts, ACNP-BC | Amanda Goke, MSN, FNP-C

Please Fill Out Pages 1-5

NURSING ENCOUNTER FORMS

Full Legal Name: _____ Appointment Date: _____
First Middle Last

Which hand do you write with? Right Left Race: _____

Male Female Age: _____ Date of Birth: _____

Referring Physician: _____

Primary Care Physician: _____

CHIEF COMPLAINT

What is your reason for seeing the Doctor?: _____

HISTORY OF PRESENT ILLNESS

How long have you had symptoms?: _____

Are symptoms getting: Worse Better Same : _____

Have you had these symptoms before?: _____

What makes symptoms better?: _____

What makes symptoms worse?: _____

Have you seen another doctor for these symptoms? Yes No If yes, who?: _____

Was medication prescribed? Yes No If yes, what?: _____

CURRENT MEDICATIONS *PLEASE LIST ADDITIONAL MEDICATIONS ON THE BACK OF THIS PAGE*

Pharmacy: _____

Medication	Dose	Frequency

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Medication List

Name: _____ Date of Birth: _____

Medication	How many mgs, mcg or ccs?	How many times each day do you take it?

Patient History

ALLERGIES TO MEDICATIONS

Medication	Reaction	Medication	Reaction
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

PAST MEDICAL HISTORY

Do you or have you had any of the following conditions? If yes, please check appropriate box.

- | | |
|---|---|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergy / Hay Fever | <input type="checkbox"/> HIV / Aids |
| <input type="checkbox"/> Anemia / Low Blood Count | <input type="checkbox"/> Liver Disease / Hepatitis |
| <input type="checkbox"/> Arrhythmias (irregular heart beat) | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lumbar Spine Disease / Low Back Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Automobile Accident with Injuries | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Menstrual / Sexual Dysfunction |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Back Injury | <input type="checkbox"/> Murmur |
| <input type="checkbox"/> Cancer-Type _____ | <input type="checkbox"/> Neck Injury |
| <input type="checkbox"/> Cervical Spine Disease / Neck Problems | <input type="checkbox"/> Neuromuscular (disease of muscles) |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Nerve Damage (disease of nerves) |
| <input type="checkbox"/> Colonic Polyps | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Drug Use | <input type="checkbox"/> Renal / Kidney Disease |
| <input type="checkbox"/> Hormone Abnormalities | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Emphysema / Lung Disease | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Genital / Urinary Disease | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Headache / Migraine | <input type="checkbox"/> Stroke (symptoms: _____) |
| <input type="checkbox"/> Headache / Tension | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Attack | |

Please list any other conditions for which you have been treated: _____

WOMEN ONLY: Date of last menstrual period? _____ Are you pregnant? Yes No

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Patient History continued

PRIOR SURGERIES OR HOSPITALIZATIONS

SURGERY	DATE	SURGERY	DATE
<input type="checkbox"/> Appendectomy / Appendicitis	_____	<input type="checkbox"/> Neck Surgery	_____
<input type="checkbox"/> Amputation	_____	<input type="checkbox"/> Pacemaker Installed	_____
<input type="checkbox"/> Arthroscopy / Knee Surgery <input type="checkbox"/> right <input type="checkbox"/> left	_____	<input type="checkbox"/> Prostate Surgery	_____
<input type="checkbox"/> Back Surgery	_____	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Brain Aneurysm	_____	<input type="checkbox"/> Tubal Ligation	_____
<input type="checkbox"/> Brain Surgery	_____	<input type="checkbox"/> Ulcer	_____
<input type="checkbox"/> Cardiac Bypass / Open Heart Surgery	_____	<input type="checkbox"/> Vasectomy	_____
<input type="checkbox"/> Carpal Tunnel Surgery <input type="checkbox"/> right <input type="checkbox"/> left	_____	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Carotidarterectomy <input type="checkbox"/> right <input type="checkbox"/> left (Blocked artery in neck)	_____		
<input type="checkbox"/> Cataract / Eye Surgery <input type="checkbox"/> right <input type="checkbox"/> left	_____		
<input type="checkbox"/> Cesarean Section	_____		
<input type="checkbox"/> Cholecystectomy / Gall Bladder	_____		
<input type="checkbox"/> Hemorrhoidectomy	_____		
<input type="checkbox"/> Hernia Repair <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> groin <input type="checkbox"/> stomach / belly button	_____		
<input type="checkbox"/> Hysterectomy	_____		
<input type="checkbox"/> Laparoscopy - Abdomen	_____		
<input type="checkbox"/> Mastectomy (Breast Surgery) <input type="checkbox"/> right <input type="checkbox"/> left	_____		

SOCIAL HISTORY

Are you a smoker? Yes No How many packs a day? _____ How long have you smoked? _____

Have you ever smoked? Yes No For how long? _____ When did you quit? _____

Do you drink alcohol? Yes No How much? _____ How often? _____ Type? _____

Have you used street drugs? Yes No If yes, what type? Marijuana Heroin Cocaine IV Drugs

Do you still use street drugs? Yes No If yes, how often? _____

Marital Status: Single Married Divorced Widowed

How far did you go in school? _____ Occupation / Job? _____

Number of children? _____ Who lives in your household? _____

Patient History continued

FAMILY HISTORY

Please Check Appropriate Answer

- Mother Living? Yes No
Healthy? Yes No
Father Living? Yes No
Healthy? Yes No
Brothers Living? Yes No
Healthy? Yes No
Sisters Living? Yes No
Healthy? Yes No

If any of your immediate family is deceased, please give age and cause of death.

List any other diseases or illnesses that run in your family:

Does anyone in your family have any of the following conditions? If so, check box and list family member (mother, father, sister, brother, etc.)

- | | |
|--|--|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Bleeding Disorder _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Brain Aneurysm _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Brain Tumors _____ | <input type="checkbox"/> Migraine / Headache _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Numb Hands or Feet _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Other _____ | |

REVIEW OF SYSTEMS - NEUROLOGIC

Do you have any of the following symptoms that you have not already explained?
Check 'No' if not applicable or circle the appropriate symptom, check 'Yes' and explain if needed

- | | Yes | No |
|---|--------------------------|--------------------------|
| General Symptoms | | |
| Fever, chills, headache, loss of appetite | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight loss or weight gain | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyes | | |
| Blurred or double vision, eye pain, blindness | <input type="checkbox"/> | <input type="checkbox"/> |
| Ears, Nose, Throat, Mouth | | |
| Ear infection, sore throat, sinus problem;
vertigo/spinning sensation;
problems with taste or smell | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory | | |
| Wheezing, cough, shortness of breath,
Coughing up blood or sputum | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiovascular | | |
| Chest pains, heart murmurs, racing heart,
irregular rhythm | <input type="checkbox"/> | <input type="checkbox"/> |

Explain Any Yes Answers:

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Patient History continued

REVIEW OF SYSTEMS - NEUROLOGIC (continued)

Do you have any of the following symptoms that you have not already explained?
Check 'No' if not applicable or circle the appropriate symptom, check 'Yes' and explain if needed

	Yes	No	Explain Any Yes Answers:
Gastrointestinal Constipation, stomach pain, nausea, diarrhea, vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder / Urinary Tract Cancer, stones, recurrent infections	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal Arthritis, joint pain, back pain muscle pain, cramps	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Rash, itching, boils, dry skin, oily skin, changes in moles	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic Seizures, numbness, tingling, dizziness, stroke, weakness, fainting, loss of vision, inability to speak	<input type="checkbox"/>	<input type="checkbox"/>	
Psychologic Depression, anxiety, memory problems	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine Tired, excess thirst, too hot / cold	<input type="checkbox"/>	<input type="checkbox"/>	
Hematologic / Lymphatic Bleeding problems, swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	
Allergic / Immunologic Seasonal allergies, AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Snoring, increased daytime sleepiness, difficulty falling asleep, difficulty staying asleep, falling asleep while driving, frequent daytime naps	<input type="checkbox"/>	<input type="checkbox"/>	
Walking Shuffling, small steps, off-balance, staggering, stumbling, tripping, walking on outside of feet, problems getting up from a chair or out of bed	<input type="checkbox"/>	<input type="checkbox"/>	

Please List Any Other Information That You Feel Is Relevant to Your Doctor Visit Today: