PREMIER NEUROLOGY INSTITUTE

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Patient Information	DOB:	SS#	Gender
Name:			
Address:			
City, State, Zip:			
Home Phone:			
Mobile Phone:		Ok to receive text confirmation? Y/ N	
Work Phone:			
Email:			
Pharmacy/Address:			

Emergency Contact Information

Name:
Relationship with you:
Phone:
Mobile Phone:
_____ I give permission to release information to this contact. (Please initial)

Authorization to release medical information to Family, Caretaker or Other:

1. Full Name: _____ Relationship _____
2. Full Name: _____ Relationship _____
3. Full Name: _____ Relationship _____

This authorization expires one year from the noted signature date below.

Patient or POA signature: Date:

IF YOU ARE A POA PLEASE PROVIDE COMPLETE FORMS

Primary/Referring Physician Information

Primary Physician: Phone:
Address:

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Medical History

Please mark major diseases you have had. Write any additional in the space below if needed

	Diabetes		Cancer
	Heart Disease		Lung Disease
	Kidney Disease		Blood Disease
	Stroke		High Blood Pressure
	Other		Thyroid Disease
	Please explain any checked above:		Gastro
	Additional past medical History not listed:		Height_____ Weight_____

Please check any of the following symptoms you have had over the last few months

	CONSTITUTIONAL		***NEUROLOGICAL***		***MUSCULOSKELETAL***
	fatigue		difficulty concentrating		joint pain
	fever		speech difficulties		recent neck injury
	loss of appetite		seizures		joint swelling
	EYES		blackout spells		muscle cramps
	eye pain		tremors		
	double vision		incoordination		***ENDOCRINE***
	blurred vision		loss of balance		polyuria
	scotoma		tingling or numbness		weight gain
	sudden visual loss		falls		weight loss
	transient visual loss		head injuries		***PYSCHIATRIC***
	photophobia		daytime hypersomnolence		anxiety
	HEENT		Arm pain/arm weakness		delusions
	headaches		hand weakness		depression
	vertigo		leg weakness/leg pain		suicidal ideation
	loss of hearing		asthma		hallucinations
	tinnitus		difficulty with fine motor skills		***HEMI-LYMPH***
			tics		easy bleeding
			stroke		easy bruising
			slowness of movements		blood transfusions
	CARDIOVASCULAR		restless legs at night		***INTEGUMENT***
	irregular heartbeat		unusual movements		rash

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	syncope		loud snoring		itching
	postural light headedness		memory loss		pigmentation changes
	Chest pain		brain fog		
	RESPIRATORY		gait difficulties		***GASTROINTESTINAL***
	shortness of breath		memory loss		reflux
	wheezing		dizziness		blood in stools
	cough		loud snoring		diarrhea
	hoarseness				

Smoker Y/N _____ Caffeine Y/N _____ Pacemaker Y/N _____ Desfibrilador Y/N_____ Alcohol Y/N_____

Other _____

List all medications you are currently taking (Including over the counter)

Drug Name	Dosage	Times/Day
Recreational drug use? Y/N	What type?	How much?
List surgeries you have had within the last 5 years:		
Allergies to food and medication?		

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MEDICATION REFILLS

Please call the office seven days before you run out of medications. Allow **48-72 hours for your prescription to be refilled.** *WE ARE NOT ABLE TO REFILL MEDICATIONS OVER THE WEEKEND*.

Signature:	Date:

NO SHOW POLICY

At Premier Neurology Institute, we understand that unexpected situations can arise. However, when a scheduled appointment is missed without notice, it leaves an empty slot that could have been used to help another patient—many of whom have been waiting weeks to be seen. We kindly ask that you notify us of any changes to your appointment as soon as possible.

Due to the increasing number of no-shows and last-minute cancellations, we have implemented the following policy:

- A **$50 no-show fee** will be charged for missed appointments without prior notification.
- This fee will **not** apply if you inform us at least **24 hours in advance** or reschedule your appointment within that timeframe.
- For your convenience, we offer a **24/7 answering service** to take messages after office hours.
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We appreciate your understanding and cooperation in helping us provide timely care to all our patients.

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FINANCIAL RESPONSIBILITIES

- **Copayments and Balances**
  Copayments and any outstanding balances are due at the time of service.

- **Insurance and Demographics**
  It is your responsibility to update your insurance and demographic information before your appointment. You will be fully responsible for any charges denied by your insurance.

- **Referrals**
  Some insurance plans require a referral from your Primary Care Physician. It is the patient's responsibility to ensure our office has a valid and updated referral before your appointment to avoid cancellation.

- **Appointments for Results**
  An appointment *is required* to review test results, labs, imaging, and procedures. Please call at your earliest convenience to schedule if needed.

- **Scheduling Tests and Procedures**
  Please allow up to 14 working days for tests or procedures (MRI, bone scan, physical therapy, etc.) to be scheduled. We send orders to the appropriate facility, which will contact you to schedule. If you have questions, call our office at **(602) 649-1555**.

- **Insurance Verification**
  Verification of coverage is not a guarantee of payment. Final financial responsibility is determined by your insurance company when the claim is processed.

- **Coverage Questions**
  Due to the large number of insurance plan policies, it is difficult for our staff to know if services are covered. For coverage questions, please contact your insurance plan directly using the number on the back of your card.

- **Delinquent Accounts**
  Outstanding balances on accounts that remain delinquent after all efforts to reach an agreement will be turned over to collections.

Signature	Date

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