MEDFORD NEUROLOGICAL & SPINE CLINIC

A Rogue Valley Physicians, P.C. Clinic

2900 STATE STREET
MEDFORD, OREGON 97504-8456
(541) 779-1672
FAX (541) 779-0986

PATIENT INFORMATION

Reviewed ____________ date ____________ initial

____________ ____________

____________ ____________

PERSONAL

Last Name________________________First________________________Middle Initial________

Mailing Address ____

City____________________State____________Zip________ Home Telephone ( )__________

Work Phone ( )______________ Email __________________ Cell Phone ( ) ____________

Home Address, *if different from above* ____

City________________________________State__________Zip ________________

Social Security Number__________________Date of Birth__________ Age______ ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Legally Separated Spouse Name:____________

If minor, Guardian/Parent Name__________________________Relationship to patient ____________

Primary Care Physician ____________________ Doctor who requested consultation at our office __________

Have you ever been a patient in our office? ❑ No ❑ Yes Date ______Previous Name?____________________

INSURANCE

WORKER'S COMPENSATION | MOTOR VEHICLE ACCIDENT | PERSONAL INJURY

❑ Job Related ❑ Motor Vehicle Accident ❑ Other Injury ❑ Not Applicable

Insurance Company Name ____

Address ____Telephone ( )____________

Employer at the time of injury (if work related)____

Date of Injury________________Claim #____________Claim Adjuster ____________________

PRIMARY MEDICAL INSURANCE

Insurance Company Name ____

Address ____Telephone ( )____________

Policy Holder's Name____________________________________Relationship to patient __________

Policy Holder's Address, *If different than patient*__________________________ Telephone ( )____________

Policy Holder's Date of Birth____________________Policy Holder's Social Security # ________________

Group #________________Group Name____________________ ID # ____________________

SECONDARY MEDICAL INSURANCE

Insurance Company Name ____

Address ____Telephone ( )____________

Policy Holder's Name____________________________________Relationship to patient __________

Policy Holder's Address, *If different than patient*__________________________ Telephone ( )____________

Policy Holder's Date of Birth____________________Policy Holder's Social Security # ________________

Group #________________Group Name____________________ ID # ____________________

(over)

PATIENT'S EMPLOYMENT

Employed: ❏ Full-time ❏ Part-time ❏ Not ❏ Retired Employer ____________________

Student: ❏ Full-time ❏ Part-time School ____________________

Work Address____________City____________State________Zip ________

Work Phone ( )____________Occupation/Position____________ Length of Employment ________

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

Name____________________Telephone ( )____________

Social Security Number____________________Date of Birth____________

Relationship to Patient____________Address____________Cell Phone ( )____________

Employer____________Occupation/Position____________ Length of Employment ________

Work Address____________________ Work Phone ( )____________

ALTERNATE CONTACT PERSON

A local friend or relative who does not live with you and can reach you in case of emergency.

Name____________________Relationship to Patient____________

Address____________________Telephone ( )____________

IN ORDER FOR OUR PHYSICIANS AND STAFF TO PROPERLY SERVE YOUR HEALTH CARE NEEDS, AND TO AVOID MISUNDERSTANDINGS REGARDING OUR PAYMENT POLICIES, PLEASE REVIEW THE FOLLOWING:

1. You are responsible for your bill. For patients without insurance, payment in full is due at the time service is rendered unless prior arrangements have been made with our Business Office.
2. Patients with insurance are responsible for any visit co-payment, percentage and/or deductible amount not yet met at the time service is rendered. As a courtesy to you, we will submit an insurance claim to your primary and secondary insurance. Any amount not covered by insurance must be paid by you.
3. MasterCard, Visa, Discover or Visa/Mastercard debit are accepted for your convenience.
4. A service charge equal to 1-1/2% per month will be applied to all account balances after 90 days.
5. Failure to make prompt and timely payments may result in a denial of future credit or service.
6. We do accept Medicare assignment. As an additional courtesy to our Medicare patients with supplemental insurance coverage, we will submit a claim form to this secondary carrier for you.
7. There is a $25.00 charge for a returned check.

I have read and understand the payment terms listed above. I authorize Medford Neurological Clinic, Inc. to release to my insurance company such medical information as they may request. I hereby assign to Medford Neurolgical Clinic, Inc. all insurance benefits for services provided by them. A photocopy of this assignment is to be considered as valid as an original.

____________________________________ ____________________

Signature of patient *(Parent/Guardian if patient is a minor)* Date

____________________________________ ____________________

Reviewed with patient Date

Rev 3/04

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CLINICAL INFORMATION QUESTIONNAIRE

PATIENT: ____
Last Name First Name Middle Initial

DATE OF BIRTH: ____________________ TODAY'S DATE: ______________

CHIEF COMPLAINT (List major problem or symptom):

____
____
____
____
____

CURRENT MEDICATIONS (List dose and frequency):
(INCLUDING SUPPLEMENTS)

Name of medication	Dosage	Frequency

DRUG ALLERGIES:

____
____
____
____
____

MEDFORD NEUROLOGICAL & SPINE CLINIC – Information Questionnaire - Page 2

Name:____________________________________ Age:___ Exam Appointment Date:______________

Referring Physician:________________________________ Handedness (Circle one): Right Left Ambidextrous

Primary Care or Family Physician:____

Operations: (appendectomy, low back, head, left leg, etc.)

____

____

Illness – history of or presently have: (please circle if yes)
Diabetes mellitus / Hypertension (high blood pressure) / Elevated cholesterol / Hypothyroidism / Coronary artery disease; heart disease; angina; heart attack / Cancer (what type)_____________________
Stroke / Asthma / COPD; emphysema. / Other____
Are you currently pregnant? Yes No Is there a chance you could be? Yes No

Past Serious Injuries:

____

Social History: Marital Status__________ **Children ?** (if yes, how many)________________________
Occupation_________________________ **Employer**____
Do you smoke/how much?___________ **Drink/how much?**_____________ **Use drugs?**________

Family History (close blood relatives) **positive for** (please circle if yes):

Diabetes / Heart attack / Stroke / Cancer / Seizures / Alzheimer's disease / Parkinson's / Multiple Sclerosis / Lou Gehrig's disease / Other____

Does a special disease run in your family?____

Have you ever had: (please circle if yes)
Bleeding tendency / Heart attack / Kidney disease / Blood clot

Are you having: (please circle if yes)
Irregular heart beat / Chest pains / Coughing / Difficulty breathing / Loss of coordination / Headache / Double vision / Nausea / Vomiting / Seizures / Change in vision / Paralysis / Weakness / Numbness / Difficulty hearing / Diarrhea / Constipation / Loss of bowel or bladder control / Painful urination / Discolored urine / Tremor / Dizziness / Change in taste or smell / Fever / Weight loss / Difficulty swallowing /. Change in voice / Fatigue / Chills / Night sweats / Poor sleep / Poor appetite / Loss of sex drive / Crying spells / Feeling sad / Skin problems / Birthmarks / Excessive bruising.