Andrew S. Gorman, DO
Jason C. Reinhart DO
Jatin Shah, MD
Atul Syal, MD

PATIENT INFORMATION

(Please print legibly)

CHART # _____ PHYSICIAN_____ DATE_____

REFERRING PROVIDER _____

Patient Name: (Last) _____ (First) _____ (Middle) _____

Social Security #_____ Driver's License #_____ State _____

Date of Birth_____ Age_____ Sex: M____ F____ Marital Status: S____ M____ D____W____

Address_____ City_____ State_____ ZIP _____

Mailing Address_____ City_____ State_____ ZIP _____

Phone: Home_____ Work_____ Cell_____ E-Mail _____

PREFERRED METHOD OF CONTACT ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Fax ☐ Patient Portal/Secure E-Mail

RACE ☐African American ☐Asian ☐Hispanic ☐Caucasian ☐Filipino ☐Native American ☐Native Hawaiian ☐Pacific Islander ☐Other

ETHNICITY ☐Hispanic ☐Non-Hispanic

Emergency Contact (other than home) _____ Phone_____

Address_____ City_____ State_____ ZIP _____

Relationship_____

Employer _____ Occupation_____ Phone_____ ext. _____

Address_____ City_____ State_____ ZIP _____

Employer (spouse)_____ Occupation_____ Phone_____ ext. _____

Address_____ City_____ State_____ ZIP _____

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while Arizona Neurology Associates, PLLC contracts with many insurance companies, it is my responsibility to verify with my plan that Arizona Neurology Associates, PLLC is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that Arizona Neurology Associates, PLLC will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If, however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize Arizona Neurology Associates, PLLC to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines.

Patient Signature_____ _____ _____

Parent/Legal Authorized Representative | Relationship to Patient | Date

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INSURANCE

Primary _____
Name of Insured_____
SS#_____
Date of Birth _____
Relationship: Self____ Spouse____ Child____ Other____
ID# _____
Group Name_____
Group #_____

Secondary_____
Name of Insured_____
SS#_____
Date of Birth _____
Relationship: Self____ Spouse____ Child____ Other____
ID# _____
Group Name_____
Group #_____

If this is a job related injury, is this the employer you were working for at the time of injury? ☐ Yes ☐ No
If due to an injury, date of loss: _____/_____/_____ First symptoms:
_____
Will an attorney or Liability Carrier be involved in payment of charges? ☐ Yes ☐ No If yes, please explain: _____
Is injury related to: ☐ Accident ☐ Auto Accident ☐ Job Related ☐ Other:
_____

If job related: Claim # _____ Case Manager: _____

Phone No.: _____

REFERRAL INFORMATION

Primary Care Physician_____ Referring Physician _____

10474 W. Thunderbird Blvd., Ste. 200, Sun City, AZ 85351
Ph: 855-50-NEURO (506-3876) - 623-377-7410 - Fax: 866-798-8023
www.azneurologyassociates.com

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NEUROLOGICAL MEDICAL HISTORY

Patient Name: (Last) _____ (First) _____ (Middle) _____

Date of Birth_____ Age_____ Height_____ Weight _____

Primary Care Physician _____ Clinic Name_____

Referring Physician _____ Clinic Name_____

Reason for Visit _____

Symptoms _____

How long have you been experiencing this pain? _____

How often does the pain occur? _____

Current pain level: No Pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Worst

What makes your pain better? _____

What makes your pain worse? _____

ALLERGIES

Do you have any history of an allergic reaction to medications or other substances?

☐No known allergies ☐Yes, specify: _____

CURRENT MEDICATIONS

Please list all medications you are currently on. Please provide a separate list if you need more room.

NAME OF MEDICATION DOSE (Include strength and number of pills per day)

1 _____

2 _____

3 _____

4 _____

5 _____

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PAST MEDICAL HISTORY

Do you have a history of any of the following?

Anxiety	☐No	☐Yes	Gastrointestinal Problems	☐No	☐Yes	Seizures	☐No	☐Yes
Asthma	☐No	☐Yes	Gerd	☐No	☐Yes	Spine Problems	☐No	☐Yes
Cancer	☐No	☐Yes	Headaches	☐No	☐Yes	Stroke	☐No	☐Yes
Depression	☐No	☐Yes	Heart Disease	☐No	☐Yes	Thyroid Disease	☐No	☐Yes
Dementia	☐No	☐Yes	Multiple Sclerosis	☐No	☐Yes	Brain or Spinal Cord Tumor	☐No	☐Yes
Diabetes	☐No	☐Yes	Neuropathy	☐No	☐Yes	Other: _____		
Ear/Nose	☐No	☐Yes	Parkinson's Disease	☐No	☐Yes	_____		
Throat	☐No	☐Yes	Restless Legs	☐No	☐Yes	_____		

FAMILY HISTORY

Memory Problems	☐No	☐Yes	Relationship:	☐Parent	☐Grandparent	☐Sibling	☐Child
Stroke/TIA	☐No	☐Yes	Relationship:	☐Parent	☐Grandparent	☐Sibling	☐Child
Epilepsy/Seizure	☐No	☐Yes	Relationship:	☐Parent	☐Grandparent	☐Sibling	☐Child
Multiple Sclerosis	☐No	☐Yes	Relationship:	☐Parent	☐Grandparent	☐Sibling	☐Child
Parkinson's Disease	☐No	☐Yes	Relationship:	☐Parent	☐Grandparent	☐Sibling	☐Child
Migraines	☐No	☐Yes	Relationship:	☐Parent	☐Grandparent	☐Sibling	☐Child

Other: _____

SOCIAL HISTORY

Occupation: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Tobacco: ☐No ☐Yes How many packs per day?____ How many years?____ ☐Quit years ago ____

Alcohol: ☐No ☐Yes How much do you drink daily? _____ ☐Quit years ago ____

Have you ever drank heavily or abused alcohol? ☐No ☐Yes

Illicit Drugs: Have you ever used any illicit substances ☐No ☐Yes Type: _____

Have you ever been addicted to or misused prescription drugs? ☐No ☐Yes Type: _____

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PAST IMAGING HISTORY

Have you recently been admitted to the hospital? ☐No ☐Yes Facility: _____
Please mark the boxes for the timeframe that any tests were done regarding your reason for visit?

☐X-Ray	☐<6 mo	☐<12 mo	Body Part: _____
☐MRI	☐<6 mo	☐ <12 mo	Body Part: _____
☐CT Scan	☐<6 mo	☐ <12 mo	Body Part: _____
☐Discogram	☐ <6 mo	☐ <12 mo	Body Part: _____
☐EMG/NCV (nerve test)	☐<6 mo	☐ <12 mo	Body Part: _____

☐Other: _____

HOSPITALIZATIONS

Please list any operations and/or hospitalizations you have had including the surgeon, year and city they took place.

	TYPE	SURGEON	YEAR	CITY
1				
2				
3				
4				
5				

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REVIEW OF SYSTEMS

Are currently experiencing any of the following symptoms?

GENERAL:			**PSYCHIATRIC**		
Loss of appetite	☐No	☐Yes	Depression	☐No	☐Yes
Recent weight loss	☐No	☐Yes	Drug/Alcohol addiction	☐No	☐Yes
Fever or chills	☐No	☐Yes	Suicidal Thoughts	☐No	☐Yes
RESPIRATORY:			**CARDIOVASCULAR:**		
Shortness of breath	☐No	☐Yes	Chest pain	☐No	☐Yes
Chronic cough	☐No	☐Yes	Palpitations	☐No	☐Yes
KIDNEY/BLADDER/URINE:			**EYES:**		
Painful urination	☐No	☐Yes	Blurred vision	☐No	☐Yes
Blood in urine	☐No	☐Yes	Double vision	☐No	☐Yes
Kidney problems	☐No	☐Yes	Loss of vision	☐No	☐Yes
GASTROINTESTINAL:			**SKIN:**		
Nausea or vomiting	☐No	☐Yes	Frequent Rashes	☐No	☐Yes
Blood in stool	☐No	☐Yes	Skin ulcers	☐No	☐Yes
Heartburn	☐No	☐Yes	Lumps	☐No	☐Yes
Constipation		☐No		☐Yes	
NEUROLOGICAL:			**HEAD/EARS/NOSE/THROAT:**		
Headaches	☐No	☐Yes	Hoarseness	☐No	☐Yes
Seizures	☐No	☐Yes	Trouble swallowing	☐No	☐Yes
Dizziness	☐No	☐Yes	Hearing loss	☐No	☐Yes
HEMATOLOGICAL/LYMPHATIC:			**ENDOCRINE:**		
Easy bruising	☐No	☐Yes	Thyroid disease	☐No	☐Yes
Easy bleeding	☐No	☐Yes	Heat/Cold intolerance	☐No	☐Yes

Have we failed to ask anything that you believe is important for us to know?

_____

_____

_____

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name: _____

Patient Signature: _____ Date: _____

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ARIZONA NEUROLOGY ASSOCIATES PLLC
HIPAA PRIVACY NOTICE

Your Individual Privacy Rights

Although your health record is the physical property of Arizona Neurology Associates PLLC, the information in your record does belong to you and, therefore, you have rights related to its uses and disclosures. *Except* as *otherwise indicated in this Notice, uses and disclosures of your PHI will be made onlv with your signed valid authorization, subject to your right to revoke your authorization.*

In addition, you have the following rights:

You may inspect and receive a *copy of your PHI. You have the right to amend your PHI. You have the right to receive an accounting of PHI disclosures:* At your request, Arizona Neurology Associates PLLC will provide you with an accounting of disclosures made by Arizona Neurology Associates PLLC. The accounting will not include disclosures made before April 30, 2016.

You have the right to receive a *paper copy of this Notice upon request. Your personal representative:* You may exercise your rights to your PHI by designating a personal representative. You must designate your personal representative **before** the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed and signed letter designating your personal representative.

• Arizona Neurology Associates PLLC will automatically consider a parent or guardian as the personal representative of an unemancipated minor (a child generally under age 18) unless applicable law requires otherwise or you restrict such disclosure. • Personal representative designations may be revoked at any time by submitting a written statement of revocation. This statement must be received by the Privacy Officer prior to a revocation becoming effective.

You have the right to file a *complaint if you believe your privacy rights have been violated.*

To exercise one or more of these rights, you should submit a signed, written statement detailing your request to the Privacy Officer listed on page one of this Notice. Arizona Neurology Associates PLLC is not required to agree to your request if the Privacy Officer determines it to be unreasonable, for example, when a custodial parent is seeking treatment for your minor child or when it would interfere with Arizona Neurology Associates PLLC's ability to file a claim.

Responsibilities of Arizona Neurology Associates PLLC

Arizona Neurology Associates PLLC is responsible for the following items:

Maintain privacy of your health information. Arizona Neurology Associates PLLC is required by law to maintain the privacy of your PHI.

Notice Distribution: Arizona Neurology Associates PLLC is required to provide you with notice of its legal duties and privacy practices. This Notice is effective beginning on April 30, 2016. However, Arizona Neurology Associates PLLC reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by Arizona Neurology Associates PLLC. If a privacy practice is changed, a revised version of this Notice will be provided to patients.

Disclosing only the minimum necessary PHI: When using or disclosing PHI, Arizona Neurology Associates PLLC will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations: • Disclosures to or requests by a health care provider for treatment

• Uses or disclosures made to you • Disclosures made to the DHHS • Uses or disclosures required by law (e.g. Public Health Agencies) • Uses or disclosures required for compliance with legal regulations (e.g. subpoenas)

Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer as follows:

Arizona Neurology Associates PLLC
Attn: HIPAA Privacy Officer
10474 W. Thunderbird Blvd., Ste. 200
Sun City, AZ 85351 (623) 377-7410

There will be no retaliation for filing a complaint. You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the DHHS.

If you need more information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact Arizona Neurology Associates PLLC's Privacy Officer.

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HIPAA PRIVACY NOTICE ACKNOWLEDEGEMENT

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Arizona Neurology Associates PLLC which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgement.

I hereby agree, Arizona Neurology Associates PLLC may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Signature of Patient/Patient's Representative

Date

Printed Name of Patient/Patient's Representative

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