Neurology and Pain Specialty Center℠

5 Journey, Suite 210
Aliso Viejo, CA 92656-5332
P: (949) 305-7122
F: (949) 305-7160
www.ocneuropain.com

PATIENT REGISTRATION

Please answer all questions completely.
Payment is expected when services are rendered.

PATIENT INFORMATION

Date: _____ Phone: (___) _____
❑ New ❑ Update

Name: _____
Last First Middle

Date of Birth: _____ Male: ❑ Female: ❑

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Cell: (___) _____ Fax: (___) _____

Email: _____

Employer: _____ Occupation: _____

Employer address: _____

Work Phone: (___) _____ Primary MD: _____

EMERGENCY CONTACT

Name: _____
Last First Middle

Relationship to Patient: _____

Address: _____

Phone: (___) _____

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INSURANCE

Bring Insurance cards to appointment to be scanned.

INSURANCE INFORMATION

Insured party: _____ Relationship to Patient: _____

Address: _____

Phone: (____) _____ Insured's SSN#: _____

Primary Insurance: _____ Subscriber ID#: _____

Group #: _____ Insured's DOB: _____

Is the patient covered by additional insurance? Yes ❑ No ❑

Secondary Insurance: _____ Subscriber ID#: _____

Group #: _____ Insured's DOB: _____

I have read and understand all of the above and hereby give my consent for medical treatment. I certify that I (or my dependent) have medical insurance coverage and assign directly to Dr. Ken Martinez insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Effective May 1, 2009 the Federal Trade Commission (FTC) has implemented a new regulation known as the Red Flag Rule requiring physicians to develop and implement identity theft detection and prevention programs. TO PROTECT YOU AGAINST IDENTITY THEFT we are required to ask for a photo ID when requesting your insurance card.

_____ _____
Signature of Responsible Party Date

_____
Relationship to Patient

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PATIENT HISTORY

Date: _____

Name: _____
Last First Middle

Date of Birth: _____ Place of Birth: _____

Ethnicity: _____ Primary spoken language: _____

Referring Physician: _____

Primary Physician: _____

Martial Status: Married ❑ Single ❑ Divorced ❑ Widowed ❑

I am: Right-handed ❑ Left-handed ❑ Ambidextrous ❑

Education Completed: 9 ❑ 10 ❑ 11 ❑ 12 ❑ 13 ❑ 14 ❑ 15 ❑ 16 ❑ 16+ ❑

Occupation: _____ Date, if retired: _____

List the main problems which bring you to the doctor:

1. _____

2. _____

3. _____

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PATIENT HISTORY CONT'D

Date: _____

Name: _____

REVIEW OF SYSTEMS:

Check boxes if you are having any of these symptoms; write in details:

GENERAL

- ❑ Chills
- ❑ Unusual fatigue
- ❑ Fever
- ❑ More than 15lb weight change in past 6 months

SKIN

- ❑ Frequent bruising
- ❑ Rashes

RESPIRATORY

- ❑ Difficulty breathing
- ❑ Persistent cough

GENITOURINARY

- ❑ Bladder incontinence
- ❑ Frequent urination
- ❑ Urinary urgency
- ❑ Burning with urination
- ❑ Erectile dysfunction

MUSCULOSKELETAL

- ❑ Joint pain
- ❑ Joint swelling
- ❑ Back pain
- ❑ Neck pain
- ❑ Neck stiffness
- ❑ Muscle spasms

GASTROINTESTINAL

- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting

EYES, EARS, THROAT

- ❑ Blurred vision
- ❑ Loss of vision
- ❑ Double vision
- ❑ New hearing loss
- ❑ Dizziness

CARDIOVASCULAR

- ❑ Chest pain or pressure
- ❑ Lightheaded on standing
- ❑ Heart palpitations (skipped heart beats)

NEUROLOGIC

- ❑ Trouble swallowing
- ❑ Confusion
- ❑ Tremor (shaking hand or head)
- ❑ Memory loss
- ❑ Balance problems
- ❑ Changes in your gait or walk
- ❑ Difficulty with speech (voice changes)
- ❑ Headaches
- ❑ Migraines
- ❑ Fainting/Loss of consciousness
- ❑ Numbness / Tingling face or extremities
- ❑ Weakness in your arms or legs
- ❑ Falls or other recent trauma
- ❑ Trouble swallowing

PSYCHIATRIC

- ❑ Anxiety
- ❑ Depression
- ❑ Hallucinations
- ❑ Insomnia
- ❑ Thoughts of suicide

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PATIENT HISTORY CONT'D

Date: _____

Name: _____

PAST MEDICAL HISTORY:

Check if you have had any of these problems:

- ❑ Angina
- ❑ Asthma
- ❑ Blindness, part or full
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Double vision
- ❑ Fainting
- ❑ Head trauma
- ❑ Headache
- ❑ Hearing problem
- ❑ Heart attack
- ❑ Heart failure
- ❑ Hepatitis
- ❑ Herniated disc
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beats
- ❑ Nervous breakdown
- ❑ Numbness
- ❑ Polio
- ❑ Psychiatric conditions
- ❑ Sciatica
- ❑ Seizures (epilepsy)
- ❑ Speech problems
- ❑ Stroke
- ❑ Swallowing problems
- ❑ Ulcers
- ❑ Venereal infections
- ❑ Vertigo
- ❑ Walking problems

PRIOR TESTS:

If you've had any of these tests, please remember to bring **FILMS** and **REPORTS** to review at the appointment.

- ❑ Angiogram of the brain (MRA)
- ❑ CAT scan (CT)
- ❑ DAT scan
- ❑ EEG (brain wave test)
- ❑ EMG (nerve-muscle test)
- ❑ Spinal tap
- ❑ Skull X-ray
- ❑ Spine X-ray
- ❑ Magnetic Resonance (MRI)
- ❑ PET scan

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PATIENT HISTORY CONT'D

Date: _____

Name: _____

MEDICATIONS:

Please list all of the medications you are currently taking. Include aspirin, birth control pills hormones, water pills, sleeping pills, tranquilizers, vitamins, etc.

	Medication	Dosage	Frequency	How long have you taken it?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

ALLERGIES:

List any allergies to medications: _____

_____

Are you allergic to X-ray dye (Iodine)? Yes ❑ No ❑ Shellfish? Yes ❑ No ❑

SURGERIES/ILLNESS:

Please list all past surgical procedures, significant illnesses or injuries.

	Surgery, Illness or Hospitalization	Year
1.		
2.		
3.		
4.		

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PATIENT HISTORY CONT'D

Date: _____

Name: _____

HABITS:

Check any of the following that you have used and state amount:

- ❑ Caffeine – how much per day? _____
- ❑ Alcohol – how much per day? _____
- ❑ Tobacco – how much per day? _____
- ❑ Recreational drugs – type/amount? _____

Do you exercise regularly? Yes ❑ No ❑ How often? _____

FAMILY HISTORY:

Have any of your relatives had any of the following?
If yes, indicate relationship (e.g., father, mother, brother):

- ❑ Alcoholism _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Heart Disease _____
- ❑ Mental Illness _____
- ❑ Migraine _____
- ❑ Seizures _____
- ❑ Stroke _____
- ❑ Tuberculosis _____

Are there any other diseases that run in the family? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor(s) or any members of their staff responsible for any errors or omission that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Provider Signature Date:

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RELEASE AUTHORIZATION

Authorization to Release Information to Family Members

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are no longer allowed to release patient information to anyone other than the patient, unless the patient gives specific written authorization. In the space below, list any family members that you give your permission for the Doctor or nurse to discuss your medical information. This permission can be rescinded at any time per the patient's verbal or written request.

Name	Relationship to Patient	Contact Information
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Authorization to Identify Self with Messages
(Authorization to leave messages on recorder)

My signature below authorizes Dr. Martinez and/or his staff to identify themselves from the doctor's office when calling to leave a message regarding my appointments, results, referrals or other medical information on any answering device or with another person answering the phone.

_____ _____
Signature Date

Notification of Insurance Information Changes

We are committed to providing you with the best possible care. If you have insurance, we are happy to submit your claims for processing. However, please be advised that you are responsible for payment of services should you fail to notify us of any changes in your insurance information before services are rendered. This would include changes in your medical group or IPA, health plan, primary physician, referring physician, benefits, and eligibility. Please submit to our office your updated insurance card to inform us of any changes in your insurance. Remember, your notification of any changes in your insurance must be submitted to us before services are rendered.

IN SIGNING BELOW, YOU ARE STATING THAT YOU HAVE:
1) READ AND UNDERSTAND THE INFORMATION CONTAINED HEREIN
2) WILL PRESENT CURRENT INSURANCE CARD AT TIME OF APPOINTMENT

_____ _____
Signature Date

_____
Print Name

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MEDICAL RELEASE AUTHORIZATION

Authorization to Obtain and Release Medical Information

This authorization allows the Neurology and Pain Specialty Center to obtain and release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that apply and require specific authorization.

I hereby authorize: _____
Physician/Healthcare Facility

to release information regarding my history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

TO: Neurology & Pain Specialty Center
Kenneth P. Martinez, MD
5 Journey, Suite 210, Aliso Viejo, CA 92656
P) 949-305-7122 F) 949-305-7160

The medical information/records will be used for the following purpose: **continued patient care.**

This authorization is: **unlimited** (all records, excluding substance abuse, mental illness & HIV.)

I also consent to the specific release of the following records: (please initial)

_____ Drug/Alcohol/Substance Abuse

_____ HIV Diagnosis/Treatment

_____ Psychiatric/Mental Health

Duration:

This authorization shall be effective immediately and remain in effect until you, the patient, change the status of the release.

Restrictions:

Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature Date

_____ _____ _____
Print Name DOB SSN:

_____ _____
Witness Signature Witness Name

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FINANCIAL POLICY

Please initial each item as you read and understand it.
Please feel free to ask us if you have any questions.

_____ Dr. Martinez is a provider for many insurance plans and we will be listed in your group's provider list if we are participating in your plan. We will bill your insurance directly and receive payment directly from them. However, to avoid confusion, be aware that we do expect payment of any applicable deductibles, co-payments or co-insurance at the time of service. Also, any services that your insurance will not cover are your responsibility.

_____ If you have an HMO insurance, it requires authorization for any of your treatment here in the office or if the Doctor refers you elsewhere. If this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred, and will be required to sign a financial waiver. If your insurance subsequently authorizes the services, your payment will be refunded upon receipt of insurance payment.

_____ If we are not a participating provider for your insurance plan, we will bill your insurance directly if you have provided us with complete information to do so. You may receive a statement for the entire charge prior to your insurance paying. You may wait to submit payment to us until after the insurance has paid its portion providing the insurance company pays within 30 days.

_____ If you do not have insurance, payment is expected at the time of service. We accept Visa, MasterCard, American Express and Discover for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Billing Office upon request.

_____ Medicare participants, you will be required to pay your percentage and any portion of deductible that has not been met or we will happily bill your secondary insurance if information provided.

_____ If you need our Doctors or medical staff to complete forms such as disability or DMV paperwork, there will be a $15 fee per page per form completed. Copies of medical records are available upon request for a $15 copy fee.

_____ Statements are mailed monthly to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact the Billing Office at (949) 709-4042 to make payment arrangements.

_____ A 24 hour advanced notice is required if you must cancel or change your appointment. Our policy is to charge for missed consultation, diagnostic testing or appointments at the rate of $50 for each missed appointment. **Our policies are created to allow for effective scheduling and to ensure all patients wishing to be seen may be accommodated. Please help us to serve you by notifying us as soon as possible if you must change or cancel your appointment.**

I have read and understand the financial and claims filing policies.

_____ _____
Signature of Responsible Party Date

_____
Relationship to Patient

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DIRECTIONS

REMINDER: Please bring your new patient paper work, insurance card, medications, and previous MRI/CT films or medical records AS REQUESTED when you scheduled your appointment.

Driving North
from SJC, San Clemente, San Diego

5 freeway North.

Exit at Oso Parkway, turn **Left**.

Take Oso Parkway approx. 6 miles.
(Note: Oso Parkway turns into Pacific Park at Moulton Pkwy).

Continue on Pacific Park up the hill through the light at Aliso Creek Rd.

Turn Left on Journey.

Take Journey one block; Turn Right.
(This Street is Journey also; Aliso Viejo library is on the right hand corner)

South Coast Health Center is the second driveway on the Right Hand Side

From Leisure World, Laguna Woods, Laguna Hills

Turn Left on Moulton Parkway.

Turn Right on Aliso Viejo Pkwy
(formerly known as Laguna Hills Dr.)

Continue straight up hill, to Pacific Park

Left on Pacific Park Drive.

Turn Right on Journey.

Take Journey one block; Turn Right.
(This Street is Journey also; Aliso Viejo library is on the right hand corner)

South Coast Health Center is the second driveway on the Right Hand Side

Driving South
from Tustin, Irvine, Los Angeles

5 freeway South.

Exit at Alicia Parkway, turn Right.

Take Alicia Parkway approx. 5 miles.

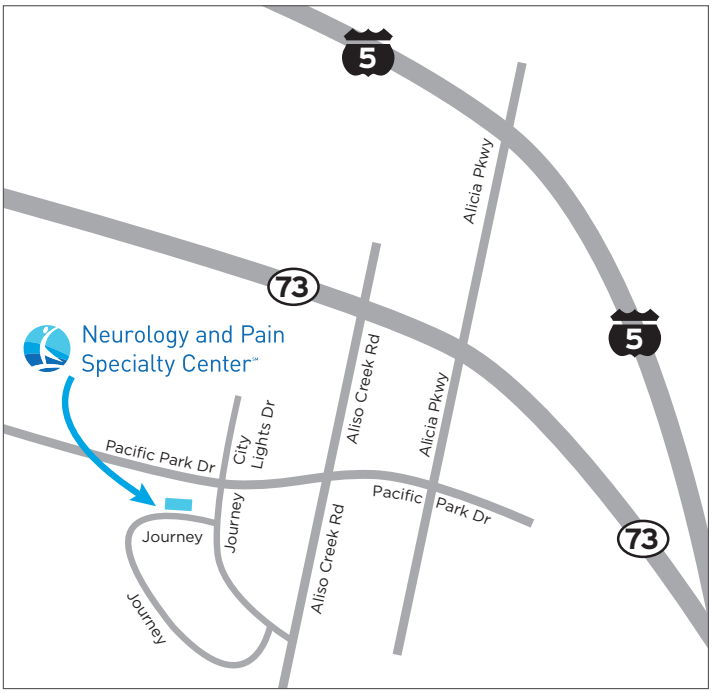
Right on Pacific Park Drive.

Continue on Pacific Park up the hill through the light at Aliso Creek Rd.

Turn Left on Journey.

Take Journey one block; Turn Right.
(This Street is Journey also; Aliso Viejo library is on the right hand corner)

South Coast Health Center is the second driveway on the Right Hand Side



Medicare, TriCare, Prospect, MHAP (St. Joseph Heritage Healthcare), BSC Admin, Workers' Comp, and most PPO Insurance Plans accepted.