**Neurology**



2301 House Ave., Suite 201 • Cheyenne, WY 82001 • (307) 638-7757 • cheyenneregional.org

Date:

**Name:**

**Date of Birth:**

**Appointment Scheduled:**

To assist us in providing the best care possible, we ask for your assistance in the following areas:

1. Please ask your referring provider to send any records, labs, radiology reports, etc. that may pertain to their referral.
2. Please show up 15 minutes early for your appointment so our front office staff will be able to check you in in a timely manner. **Patients that are more than 10 minutes late may be rescheduled to a later time or date.**
3. Please bring a list of your current medications, prescribed and over the counter.

Please bring your **Insurance Card**, **Copayment** and a **Photo ID.**

If you do not have Medical Insurance or CRMC Charity Care your **NEW PATIENT VISIT DEPOSIT IS $180.00** and your **FOLLOW UP VISIT DEPOSIT IS $120.00.** This is required at the time of service and is not the total cost of your appointment.

We look forward to seeing you soon. If you have any questions or need to reschedule your appointment, **please call the office at 307-638-7757.**

Thank you,

The Medical Specialty Clinic Staff

**Medical Specialty Clinic: Neurology**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_**

**Primary Care Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referring Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**: **Circle All That Apply**  
**Do You Have a History of:** High Blood Pressure / High Cholesterol / Heart Disease / Lupus / Atrial Fibrillation / Stroke / Diabetes / Cancer / COPD / Lung Disease / Depression / Seizure / Aneurysms /Arthritis / Multiple Sclerosis / Migraines / Neuropathy / Pacemaker / Head Injury  
  
**Does Anyone in Your Family (Parents, Siblings or Children) Have:** Diabetes / Hypertension /   
 High Cholesterol / Cancer / Neuropathy / Seizures / Strokes / Migraine

**Have You Had Surgery on Your:** Back / Neck / Carpal Tunnel / Cancer (What kind? \_\_\_\_\_\_\_\_\_\_\_)

**Social History:**

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Education Level:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do You Smoke?** Never / Former (Quit Date :\_\_\_\_\_\_\_\_) / Yes (How many packs per day? \_\_\_\_\_\_\_\_\_\_)   
**Do You Drink Alcohol?** No / Yes (How much? \_\_\_\_\_\_\_\_\_\_\_)  
 When was your last drink? \_\_\_\_\_\_\_\_\_\_\_ Do you have history of withdrawal seizures? No / Yes

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| --- | --- | --- |
| **Current Medication** | **Dosage** | **Frequency** |
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**Do You or Have You Used Street Drugs?** No / Yes (What drug? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Allergies to Medications (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you having any problems taking your medications as prescribed? No / Yes**

If yes, why? (Circle) Cost Side effects Ineffective Trouble remembering medications

**In the last month, have you had any of the following symptoms? (Circle the symptom)**

**General:** Weight loss Weight Gain Dizziness

**Eyes:** Blurred Vision Loss of Vision Double Vision

**Ear/Nose/Throat:** Tinnitus Hearing Loss Trouble Swallowing Trouble speaking

**Lungs:**  Shortness of Breath Do you use oxygen? No / Yes Do you use a CPAP? No / Yes

**Cardiovascular:** Dizziness with standing High Blood Pressure Swelling of Feet

**GI:** Diarrhea Constipation Nausea or Vomiting

**Urinary:** Urinary tract infection Can’t urinate Incontinence (accidents) Blood in Urine Kidney Stones

**Musculoskeletal:** Neck pain Low Back Pain Joint Pain Muscle Aches

**Neurologic:** Numbness or Tingling Weakness Balance problems Unsteady while walking

Falls Nervous About Falling Trouble Concentrating Memory Loss Hallucinations

**Headaches:** How many days of headache have you had in the last month? \_\_\_\_\_\_

How many days per month do you get a severe headache that limits your ability to function? \_\_\_\_\_\_\_

On average how many days in the past month did you take acute (as needed) medication? \_\_\_\_\_\_\_\_\_\_

**Seizures:** When was your last seizure? \_\_\_\_\_\_\_ How many seizures have you had since your last visit? \_\_\_\_\_\_\_

Have your seizures changed since your last visit? No / Yes If yes, how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any injuries because of your seizures? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep:** Can’t Fall Asleep Can’t Stay Asleep Snoring Acting out Dreams Sleep Apnea

**Mental health:** Depression Anxiety Irritability

**Skin/Heme:** Rash Easy Bleeding Easy Bruising

**Endocrine:** Cold intolerance Heat Intolerance Diabetes

**Reproductive:** Decreased libido **Currently pregnant?** No /Yes Are you **planning** on becoming pregnant? No/ Yes



**STAMPER OR PATIENT LABEL**

**Authorization to Disclose Health Information to Family or Other**

Patient’s Name: Date of Birth:

Street Address:

City: State: Zip:

I hereby authorize Cheyenne Regional Medical Center to disclose health information to the following contact(s):

**Contact #1**

Name: Relationship to me:

Home Phone: Alternate Phone:

**Contact #2**

Name: Relationship to me:

Home Phone: Alternate Phone: \_\_\_\_\_\_

The information that may be disclosed or discussed is related to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(e.g. current treatment, related to incident)

for the purpose of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and may include the following:

🞏 Treatment and Progress Notes 🞏 Nursing Records

🞏 Treatment Plans 🞏 Lab(s)

🞏 Financial Records 🞏 Medications

🞏 Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Once your health information has been disclosed, re-disclosure of your health information by the recipient may no longer be protected by law. You may revoke this authorization in writing at any time. Please note that cancellation by telephone must be confirmed in writing. Your revocation will not affect any disclosure made under this authorization prior to your revocation.

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

By signing this form I understand that Cheyenne Regional Medical Center may discuss past, present, or future health care issues with the above named contacts from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start End (not more than 1 year from the date of this authorization)

Signature: Date:

If Personal Representative Signed:

Personal Representative Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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ROI

\*ROI\*

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| --- | --- | --- | --- | --- |
| Name: (Last, First MI)  *Preferred Name:* | | Sex (M/F) | Birth Date: | |
| Mailing Address: | | | Social Security #: | |
| City, State, Zip: | | | Primary Care Provider: | |
| Phone Numbers: *Check Which Number is Preferred*  HOME # MOBILE # WORK #  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Referring Provider: | |
| Email: | |
| *Emergency Contact Name:* | *Contact Relationship:* | | *Emergency Contact Phone:* | |
| **Check next to the box that applies:**  *These questions are used for hospital survey purposes*  **Marital Status: Ethnicity: Race:**  Married Hispanic/Latino American Indian or Alaskan Native  Single Not Hispanic or Latino Asian  Divorced Unknown Black or African American  Widowed More than One Race  Separated Native Hawaiian  Partner Pacific Islander  Other White/Caucasian  Other | | | | **Primary Language:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Preference of Religion:**  **U.S State of Birth:**  If *OTHER* please check box |
| ***How did you hear about us?*** |
| **Employer:** | | | | Full Time Student N/A  Part Time Retired |

|  |  |  |  |
| --- | --- | --- | --- |
| **Guarantor/Responsible Party**: If ***SELF*** (Same as above info Check Box) *If different, please fill out below:* | | | |
| Relationship to Patient: | Best Phone Number: | | |
| Name: (Last, First, Middle) | | Sex (M/F) | Birth Date: |
| Mailing Address: | | City, State, Zip: | |

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| **INSURANCE:** *If you are going through Workers Compensation skip to the last section* | | | |
| **PRIMARY INSURANCE COVERAGE:** | | **SECONDARY INSURANCE COVERAGE:** | |
| *Policy Holder Name:* | *Relationship to Patient:* | *Policy Holder Name:* | *Relationship to Patient:* |
| *Policy #* | *Group #* | *Policy #* | *Group #* |
| *Insurance Start Date:* | | *Insurance Start Date:* | |
| ***WORKERS COMPENSATION CLAIM # Date of Injury:*** | | | |



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**CANCELLATION AND MISSED APPOINTMENT/NO SHOW PROCEDURE**

Dear Valued Patient,

Our goal is to provide timely quality medical care. No-Shows and late cancellations inconvenience those who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for all of our patients.

**CANCELLATION OF AN APPOINTMENT**

In order to be respectful of the medical needs of other patients, please be courteous and call the Medical Specialty Clinic promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

**HOW TO CANCEL YOUR APPOINTMENT**

To cancel an appointment, please call (307) 638-7757. If you do not reach the receptionist you may leave a detailed message on our voicemail. Please leave your name and phone number and we will return your call to give you the next available appointment time.

**LATE CANCELLATION**

A late cancellation is someone who does not cancel their appointment before 24 hours of their scheduled appointment time.

**NO-SHOW PROCEDURE**

A “no-show” is someone who fails to arrive for a scheduled appointment without cancelling the appointment prior to the scheduled time.

* First no show: There will be no charge
* Second no show: May result in a $25 fee billed to your account
* Third no show: May result in an additional $25 fee billed to your account and dismissal from our practice.

***I have read and understand the Medical Specialty Clinic Cancellation and Missed Appointment/No Show Procedure.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Printed Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Today’s Date

***The Medical Specialty Clinic values you as a patient and strives to provide you with excellent medical services! Thank you for your support of this process****.*