New Patient Registration Packet

How to schedule a new evaluation or consultation:

We will schedule a new patient appointment on a **"Referral Only"** basis. If we are seeing you thru Medicare or private commercial insurance, your *Primary Care Physician* must refer you to us. If we are seeing you as a Work Injury or for an IME, then your insurance company, or an Attorney, or a Nurse Case Manager can refer you to us.

If this evaluation involves an "Auto Accident"

If you are being seen for injuries sustained in a non-Work Comp auto accident, PLEASE contact our office BEFORE your office visit. We will need to discuss financial issues with you prior to your office visit.

X-rays, CT scans, and MRI scans:

If you have had any x-rays, CT scans, or MRI scans, you must make sure those **reports** are forwarded to our office BEFORE your office visit. Due to Hipaa Security Policies, we will NOT be able to view outside films if they are on a disc or USB. Please DO NOT drop off the films before your visit, as this will increase the chances of our office losing your films.

Appointment Time

We only see new patients between **8:30 AM and 2:00 PM**, Monday thru Thursday's. Please arrive approximately 15 minutes before your scheduled appointment. This will also give us time to enter your information into the computer and put together a "medical chart" in your name.

*** If you cannot keep your scheduled appointment, PLEASE call us as soon as possible. ***

Validate Your Identity

We must verify your identity prior to being seen. PLEASE bring a Driver's License or an official State ID to validate your identity. We will make a copy of your ID for our records.

Insurance Coverage

You must bring a copy of your current Insurance Card or Medicare Card. Without proof of current insurance coverage, we may not be able to see you as a patient.

Medical Records:

We must have all of your recent and relevant medical records BEFORE an appointment can be made. Specifically, if you have seen another Neurologist, we must be forwarded those medical records, which we will REVIEW before an appointment is made.

Medications

Please bring ALL your actual medications (NOT just a list), so Dr. Athni will have the option to review them with you.

Registration Checklist

- ***FIRST: DOWNLOAD THIS FORM***
- On the following pages, you will find our 3 page Registration Form.
- **Please fill out these PDF Registration forms ON YOUR COMPUTER and SAVE a copy on your computer.**
- At the bottom of the last page, there is a “Submit Form” button, which will allow you to send the form via email.
    - *The “Submit Form” will only work if this PDF has been downloaded to your computer.*
- Please PRINT OUT a copy of this form in case there is an error in email transmission.
- If you are unable to sign these forms on your computer, we will have you sign the form when you come to the office.
- DO NOT modify these forms, else you will be required to fill out these forms again in the office.

- If you fill out these forms using a pen, PLEASE use BLACK ink, as blue ink will not “scan” properly into our medical records system
- PLEASE do NOT write on the back side of these pages.
- PLEASE do NOT print these pages “back to back” – print each page on a separate page so we will be able to scan these pages into our medical records system

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Your Checklist

EMAIL the completed **Registration Form** – 3 pages via the “Submit Form” button

If unable to Email, please PRINT the Registration Form and bring it with you

Bring your **Driver's License** or Official State ID with picture

Bring your current **Insurance Card**

Bring all your current **medications** (not just a list)

X-rays, CT Scans and MRI – official **Radiology reports**

DEMOGRAPHIC INFORMATION

Patient Name:

Address:

City:

State: Zip:

Mobile #

Work #

Email :

Date of Birth:

Current Age:

Gender: Male Female

Race: White Black Asian

Other:

Ethnicity: Hispanic NOT-Hispanic

Primary Language: English

Other:

Social Security #

Spouse Name:

Spouse Mobile #

REFERRAL INFORMATION

Who referred you to our office?

Main reason for today's office visit?

INSURANCE & BILLING

Primary Insurance:

Secondary Insurance:

EMPLOYER INFORMATION

Employer:

Employer Address:

Work Injury? YES NO

Auto Accident? YES NO

Date of Injury:

Attorney name & Phone #

How many CHILDREN?	# BOYS		# GIRLS		
MARITAL STATUS	Single	Married	Separated	Divorced	Widowed
SCHOOLING	Finished Grade 4 yr College		High School Masters		2 yr College Doctorate
WORK STATUS	Working Full-Time Retired		Working Part-Time Unemployed		Work-Comp Leave
HAND DOMINANCE	Right Handed		Left Handed		Ambidextrous

HABITS	Currently Use?		If NO, any PAST Use?		Details of Use
Smoking (cigars, cigarettes)	YES	NO	YES	NO	
Alcohol (wine, beer, hard liquor)	YES	NO	YES	NO	
Marijuana, CBD	YES	NO	YES	NO	
Other (cocaine, crack, meth, etc)	YES	NO	YES	NO	

MILITARY SERVICE	YOU		YOUR SPOUSE	
Currently ACTIVE DUTY?	YES	NO	YES	NO
Or, are you RETIRED from the Military?	YES	NO	YES	NO
Which BRANCH of the Military did you serve?				
Highest RANK achieved?				
Do you have TRICARE Insurance?	YES	NO	YES	NO
Do you have any OTHER Health Insurance?	YES	NO	YES	NO
Name of OTHER Health Insurance:				

Patient OR Guardian Signature ______________________________ Date

If Responsible Person is a Parent/Guardian, Please Print Your Name

MEDICATIONS	STRENGTH	HOW OFTEN DO YOU TAKE IT?

OTHER Medications?

ALLERGIES:

MEDICAL PROBLEMS:

High Blood Pressure	Diabetes	Low Thyroid	GE Reflex
Prior Strokes	Heart Disease	Prior Heart Attacks	COPD
High Cholesterol	CHF (Heart Failure)	Depression	Anxiety

ANY OTHER MEDICAL PROBLEMS:

PAST SURGERIES	Any OTHER Surgery	Date of Surgery
Gall Bladder (date)		
Appendix (date)		
Hysterectomy (date)		
Mastectomy (date)		
Cervical Fusion (date)		
Lumbar Fusion (date)		
Heart Bypass (date)		
Heart Cath (date)		

Patient OR Guardian Signature ______________________ Date

If Responsible Person is a Parent/Guardian, Please Print Your Name

To email this registration form, click "Submit Form." Please bring a copy of the completed form in case there is an error in email transmission.