Registration Form

Date: _____ / _____ / _____ Are you a new patient: ☐ Yes ☐ No

Physician Name: _____ Referring Physician: _____

PATIENT INFORMATION (Please Print)

Name: (First/Middle/Last) _____ D.O.B.: _____

Address: _____

City, State, Zip: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security #:_____ Patient Sex: ☐ M ☐ F

Marital Status: ☐ M ☐ S ☐ D ☐ W

Spouse Name: _____ D.O.B.: _____

Please circle:

Race: Alaskan Native American Indian Asian African American Hispanic or Latino Indian White

Language: Chinese English French German Italian Japanese Somali Spanish Vietnamese Other

Ethnicity: Hispanic or Latino Non Hispanic or Latino

Email Address: _____

Contact Preference: home# _____ cell# _____ day# _____

Guarantor Name: _____ D.O.B.: _____

Guarantor Address (if different): _____

City, State, Zip: _____

Insurance Provider: _____ Name of Insured: _____

Group Name: _____ Policy#: _____ Group#: _____

In Case of Emergency (Someone at different phone number)

Name: _____ Relationship: _____

Phone#: _____ Alternate#: _____

Patient Signature: _____ Date: _____

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Revised 1.10.2022

927 North James Campbell Boulevard | Suite 105 | Columbia, Tennessee 38401-2755
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Patient Authorization for Use and Disclosure of Protected Health Information

1. By signing this Authorization, I authorize **Advanced Neurology & Sleep** to disclose protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name: _____ Relationship: _____

Method of Communication: _____

Name: _____ Relationship: _____

Method of Communication: _____

2. May we contact you regarding your protected health information, health status, appointments, and test results?

☐ Yes, you may contact me by email, my address is: _____

☐ No, do not contact me by email for this purpose.

☐ Yes, you may contact me by phone, my daytime phone numbers are:

(_____) _____ (_____) _____

Can we leave a message regarding your protected health information at the numbers you provided above? ☐ Yes ☐ No

☐ No, do not contact me by phone for this purpose.

3. May we send you newsletters and other marketing information by email?

☐ Yes, please use the following email address: _____

☐ No, I do not want to be sent newsletters or other marketing information.

I understand that I do not have to sign this Authorization in order to receive treatment and revocation of any authorizations will not affect my ability to continue receiving treatment.

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any re-disclosures of my health information by a third party may no longer be protected under federal or state privacy laws.

I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, and sickle cell anemia or HIV infection.

I understand that this Authorization will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this Authorization to the address below or send an email to the address at the bottom of this Authorization. However, any disclosure that occurred prior to the date of the revocation will not be affected.

I understand that no protected health information (other than as outlined by the Health Insurance Portability and Accountability Act and in the Practice Notice of Privacy Practices, a copy of which I have received) can be released to anyone, including spouses, parents, other family members, significant others or friends without this Authorization.

Patient Signature: _____ Date: _____

Printed Patient Name:_____ DOB: _____

Signature of Patient Representative: _____ Date: _____

Printed Name of Patient Representative: _____ Relationship: _____

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Patient Information

Louise Y. (Lucy) Ledbetter, MD, MBA
Laura J. Roberts, ACNP-BC | Amanda Goke, MSN, FNP-C | Erika Crowell, MSN, FNP-BC

CONSENT FOR MEDICAL TREATMENT: I, the undersigned, hereby consent to any medical treatment rendered to me under the general and special instructions of the health care provider in charge. In the event an employee is accidentally exposed to my blood/bodily fluids, I hereby consent to the testing of my blood as deemed necessary by the health care provider. I also acknowledge that the health care provider can make no guarantee or warranty to any treatment or service rendered.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to **Advanced Neurology & Sleep** the insurance benefits due for any treatment of service provided. I understand that in billing the insurance company, a diagnosis may be used that is considered confidential information.

FINANCIAL AGREEMENT: I understand that payment for medical services in this office for my dependants or myself is due and payable at the time services are rendered unless other arrangements have been made. Services not covered by my insurance plan are my responsibility. It is my responsibility to understand my health insurance benefits and what is not covered.

DISCLOSURE OF MEDICAL INFORMATION: I authorize the practice to release my medical information for the purpose of providing, coordinating or managing health care and related services. I authorize the practice to disclose my medical information to obtain payment for services provided to me.

NOTICE OF PRIVACY PRACTICES: The privacy notice describes ways in which we may use and disclose medical information. The notice also describes my rights and legal obligations with regard to my medical information. My signature below acknowledges that I have been given a copy of **Advanced Neurology & Sleep's** privacy notice.

MEDICARE/TENNCARE/CHAMPUS PATIENTS: If I am a Medicare, TennCare or Champus patient, I certify that the information I provided when applying for payment under the Social Security Act is correct.

RETURN CHECK POLICY: I understand that I will be charged a $25.00 fee for any returned checks.

Patient Name Printed: _____ Date: _____

Signature: _____ Date: _____

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New Patient Form

Louise Y. (Lucy) Ledbetter, MD, MBA
Laura J. Roberts, ACNP-BC | Amanda Goke, MSN, FNP-C | Erika Crowell, MSN, FNP-BC

Please Fill Out Pages 1-5

NURSING ENCOUNTER FORMS

Full Legal Name: _____ Appointment Date: _____
First Middle Last

Which hand do you write with? ☐ Right ☐ Left Race: _____

☐ Male ☐ Female Age: _____ Date of Birth: _____

Referring Physician: _____

Primary Care Physician: _____

CHIEF COMPLAINT

What is your reason for seeing the Doctor?: _____

_____

HISTORY OF PRESENT ILLNESS

How long have you had symptoms?: _____

Are symptoms getting: ☐ Worse ☐ Better ☐ Same : _____

Have you had these symptoms before?: _____

What makes symptoms better?: _____

What makes symptoms worse?: _____

Have you seen another doctor for these symptoms? ☐ Yes ☐ No If yes, who?: _____

Was medication prescribed? ☐ Yes ☐ No If yes, what?: _____

CURRENT MEDICATIONS *PLEASE LIST ADDITIONAL MEDICATIONS ON THE BACK OF THIS PAGE*

Pharmacy: _____

Medication	Dose	Frequency

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Medication List

Name: _____ Date of Birth: _____

Medication	How many mgs, mcg or ccs?	How many times each day do you take it?

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Patient History

ALLERGIES TO MEDICATIONS

Medication	Reaction	Medication	Reaction
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

PAST MEDICAL HISTORY

Do you or have you had any of the following conditions? If yes, please check appropriate box.

- ☐ Alcohol Abuse
- ☐ Allergy / Hay Fever
- ☐ Anemia / Low Blood Count
- ☐ Arrhythmias (irregular heart beat)
- ☐ Arthritis
- ☐ Asthma
- ☐ Automobile Accident with Injuries
- ☐ Bleeding Problems
- ☐ Brain Tumor
- ☐ Back Injury
- ☐ Cancer-Type _____
- ☐ Cervical Spine Disease / Neck Problems
- ☐ Circulation Problems
- ☐ Colonic Polyps
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Drug Use
- ☐ Hormone Abnormalities
- ☐ Emphysema / Lung Disease
- ☐ Epilepsy / Seizures
- ☐ Genital / Urinary Disease
- ☐ Head Injury
- ☐ Headache / Migraine
- ☐ Headache / Tension
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ HIV / Aids
- ☐ Liver Disease / Hepatitis
- ☐ Loss of Consciousness
- ☐ Lumbar Spine Disease / Low Back Pain
- ☐ Measles
- ☐ Meningitis
- ☐ Menstrual / Sexual Dysfunction
- ☐ Mumps
- ☐ Murmur
- ☐ Neck Injury
- ☐ Neuromuscular (disease of muscles)
- ☐ Nerve Damage (disease of nerves)
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Renal / Kidney Disease
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Diseases
- ☐ Shingles
- ☐ Smoking
- ☐ Spinal Cord Injury
- ☐ Stroke (symptoms:_____)
- ☐ Thyroid Disease

Please list any other conditions for which you have been treated: _____

_____

WOMEN ONLY: Date of last menstrual period? _____ Are you pregnant? ☐ Yes ☐ No

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Patient History continued

PRIOR SURGERIES OR HOSPITALIZATIONS

SURGERY	DATE	SURGERY	DATE
☐ Appendectomy / Appendicitis	_____	☐ Neck Surgery	_____
☐ Amputation	_____	☐ Pacemaker Installed	_____
☐ Arthroscopy / Knee Surgery ☐ right ☐ left	_____	☐ Prostate Surgery	_____
☐ Back Surgery	_____	☐ Tonsillectomy	_____
☐ Brain Aneurysm	_____	☐ Tubal Ligation	_____
☐ Brain Surgery	_____	☐ Ulcer	_____
☐ Cardiac Bypass / Open Heart Surgery	_____	☐ Vasectomy	_____
☐ Carpal Tunnel Surgery ☐ right ☐ left	_____	☐ Other: _____	
☐ Carotidendarterectomy ☐ right ☐ left (Blocked artery in neck)	_____		
☐ Cataract / Eye Surgery ☐ right ☐ left	_____		
☐ Cesarean Section	_____		
☐ Cholecystectomy / Gall Bladder	_____		
☐ Hemorrhoidectomy	_____		
☐ Hernia Repair ☐ right ☐ left ☐ groin ☐ stomach / belly button	_____		
☐ Hysterectomy	_____		
☐ Laparoscopy - Abdomen	_____		
☐ Mastectomy (Breast Surgery) ☐ right ☐ left	_____		

SOCIAL HISTORY

Are you a smoker? ☐ Yes ☐ No How many packs a day? _____ How long have you smoked? _____

Have you ever smoked? ☐ Yes ☐ No For how long? _____ When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____ How often? _____ Type? _____

Have you used street drugs? ☐ Yes ☐ No If yes, what type? ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ IV Drugs

Do you still use street drugs? ☐ Yes ☐ No If yes, how often? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How far did you go in school? _____ Occupation / Job? _____

Number of children?_____ Who lives in your household? _____

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Patient History continued

FAMILY HISTORY

Please Check Appropriate Answer

Mother Living? ☐ Yes ☐ No
Healthy? ☐ Yes ☐ No
Father Living? ☐ Yes ☐ No
Healthy? ☐ Yes ☐ No
Brothers Living? ☐ Yes ☐ No
Healthy? ☐ Yes ☐ No
Sisters Living? ☐ Yes ☐ No
Healthy? ☐ Yes ☐ No

If any of your Immediate family Is deceased, please give age and cause of death.

List any other diseases or Illnesses that run In your family:

Does anyone In your family have any of the following conditions? If so, check box and list family member (mother, father, sister, brother, etc.)

☐ Arthritis _____
☐ Bleeding Disorder _____
☐ Brain Aneurysm _____
☐ Brain Tumors _____
☐ Cancer _____
☐ Diabetes _____
☐ Epilepsy _____
☐ Other _____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ Kidney Disease _____
☐ Migraine / Headache _____
☐ Numb Hands or Feet _____
☐ Stroke _____
☐ Thyroid Disease _____

REVIEW OF SYSTEMS - NEUROLOGIC

Do you have any of the following symptoms that you have not already explained?
Check 'No' if not applicable or circle the appropriate symptom, check 'Yes' and explain if needed

	Yes	No
General Symptoms		
Fever, chills, headache, loss of appetite	☐	☐
Weight loss or weight gain	☐	☐
Eyes		
Blurred or double vision, eye pain, blindness	☐	☐
Ears, Nose, Throat, Mouth		
Ear infection, sore throat, sinus problem; vertigo/spinning sensation; problems with taste or smell	☐	☐
Respiratory		
Wheezing, cough, shortness of breath, Coughing up blood or sputum	☐	☐
Cardiovascular		
Chest pains, heart murmurs, racing heart, irregular rhythm	☐	☐

Explain Any Yes Answers:

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Patient History continued

REVIEW OF SYSTEMS - NEUROLOGIC (continued)

Do you have any of the following symptoms that you have not already explained?
Check 'No' if not applicable or circle the appropriate symptom, check 'Yes' and explain if needed

	Yes	No
Gastrointestinal Constipation, stomach pain, nausea, diarrhea, vomiting	☐	☐
Bladder / Urinary Tract Cancer, stones, recurrent infections	☐	☐
Musculoskeletal Arthritis, joint pain, back pain muscle pain, cramps	☐	☐
Skin Rash, itching, boils, dry skin, oily skin, changes in moles	☐	☐
Neurologic Seizures, numbness, tingling, dizziness, stroke, weakness, fainting, loss of vision, inability to speak	☐	☐
Psychologic Depression, anxiety, memory problems	☐	☐
Endocrine Tired, excess thirst, too hot / cold	☐	☐
Hematologic / Lymphatic Bleeding problems, swollen glands	☐	☐
Allergic / Immunologic Seasonal allergies, AIDS	☐	☐
Sleep Snoring, increased daytime sleepiness, difficulty falling asleep, difficulty staying asleep, falling asleep while driving, frequent daytime naps	☐	☐
Walking Shuffling, small steps, off-balance, staggering, stumbling, tripping, walking on outside of feet, problems getting up from a chair or out of bed	☐	☐

Explain Any Yes Answers:

Please List Any Other Information That You Feel Is Relevant to Your Doctor Visit Today:

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