Date of Visit: _____

First Name: _____ Middle_____ Last_____ AKA_____ DOB_____

Address: _____ City: _____ State: _____ Zip: _____

Home #:_____ Cell #:_____ Work # _____

Email address_____ SS # _____

**Preferred Method of Contact: ❑ Home ❑ Cell ❑ Work ❑ Email

**May we leave messages about appointments and results? (Check all that apply) ❑ Yes ❑ No

❑ Home ❑ Cell ❑ Work

Gender: ❑ M ❑ F Marital Status: _____ Spouse's Name: _____

Employer: _____ Occupation: _____

Race/Ethnicity: _____ Preferred Language: _____ Interpreter Needed: ❑ Yes ❑ No

Family Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Minor Patients: Child lives with: _____ Contact #:_____

Mother/Guardian:_____ Contact #:_____

Father/Guardian: _____ Contact #: _____

Responsible Party, if different than above

Name: _____ Relationship to Patient: _____

Address: _____ Phone: _____

Primary Insurance: _____ Employer: _____

Policy Holder: _____ DOB: _____ Relationship: _____

ID/ SS#: _____ Group #: _____

Secondary Insurance: _____ Employer: _____

Policy Holder: _____ DOB: _____ Relationship: _____

ID/SS#: _____ Group #: _____

Is today's visit related to an accident? ❑ No ❑ Yes Date of Accident _____

OhioHealth

PATIENT IDENTIFICATION LABEL

REGISTRATION FORM

If work related, please complete the following questions:

Employer: _____ Address: _____ Phone #: _____

Date of Injury: _____ Claim #:_____

Allowed Diagnosis: _____

MCO: _____ Phone#: _____

Case Manager: _____ Phone#: _____

Have you filed paperwork with your employer? ❑ No ❑ Yes

Do you have an attorney? ❑ No ❑ Yes

Name: _____ Phone#: _____

Many of our patients during their recovery may stay with family members, friends or at a rehabilitation or nursing facility. Please provide our office staff with information as to where you are currently staying so we are able to contact you.

I am staying with a: ❑ Relative ❑ Friend ❑ Rehabilitation Center ❑ Skilled Nursing Facility

Name of Relative/Friend/ Facility: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you have a Health Care Power of Attorney? ❑ No ❑ Yes

Name of POA: _____ Contact #: _____

(If yes, please provide a copy of the POA documents)

With whom may we contact in case of an emergency or leave medical information with? Indicate whether or not we may discuss medical/financial information pertinent to your treatment with this person.

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Patient/Guardian Signature: _____ Date: _____ Time: _____

OhioHealth Neurological Physicians

Patient Information Form

Name:_____ Date of Birth:_____ Age:_____
Which hand do you write with?_____

Briefly describe the reason you are here:_____
_____

What other physicians have you seen for this problem (if any)?_____
_____

CURRENT MEDICATIONS

Please list medications, how often you take them, and how much: ☐None

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

If more than 12, please list on the back of this form and check here: ☐

ALLERGIES (Very Important!) To any drugs, dyes, or tape. **☐No Known Allergies**

1._____ 4._____
2._____ 5._____
3._____ 6._____

Have you ever been HOSPITALIZED or had SURGERY? ☐Never hospitalized ☐Never had surgery

Reason for hospital stay/surgery	Year	Doctor
1.		
2.		
3.		
4.		
5.		

If more than 5 hospitalizations or surgeries, please list on the back of this form and check here: ☐

Tobacco: Do you smoke? ☐No ☐Yes ☐Previously *If yes*: Packs per day:_____ For how long:_____

Caffeine: How many cups of coffee, tea, and/or soft drinks do you consume per day: _____

Alcohol: Do you drink alcohol? ☐No ☐Yes *If yes:* Type:_____ How Often?_____

Drugs: Have you *ever* used drugs? ☐No ☐Yes Do you *still* use drugs? ☐No ☐Yes
If yes to either: Type:_____ How Often?_____

For test ordering purposes, please indicate whether you have any of the following:

☐Allergy to X-ray Contrast dye ☐Pacemaker ☐Any kind of metal implant ☐Claustrophobia

Name:

Do you have any of the following?

Health Condition	No	Yes	Since When?
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Diabetes	☐	☐	
Heart Trouble	☐	☐	
Cancer	☐	☐	
Migraine Headaches	☐	☐	
Seizures	☐	☐	
Asthma/Breathing Problems	☐	☐	
Stomach Problems	☐	☐	

Health Condition	No	Yes	Since When?
Hepatitis	☐	☐	
HIV / AIDS	☐	☐	
Psychiatric/Emotional Problems	☐	☐	
Muscle Diseases	☐	☐	
Head Injury	☐	☐	
Neck Injury	☐	☐	
Back Injury	☐	☐	
Problems With Anesthesia	☐	☐	
	☐	☐	

Please list any other health problems you have:_____

_____

What tests or procedures have been done so far for your problem? Check all that apply, and *please indicate the facility where the test/treatment was performed.*

☐CT Scan of:_____
☐MRI scan of:_____
☐X-Rays of:_____
☐EMG of:_____
☐EEG:_____
☐Injections:_____
☐Physical Therapy:_____
☐Pain Management:_____
☐Angiogram:_____
☐Lumbar Puncture:_____
☐Myelogram:_____
☐Carotid Doppler:_____
☐TENS Unit:_____
☐Other:_____

List any medications you have previously tried for this problem:

_____
_____
_____
_____

Diet(Special diet/eating habits):_____

_____

Exercise: ☐ Yes ☐ No

Type/frequency_____

_____

What health problems run in your family?_____

_____

Family Member	**Alive**	**Deceased**	**Age**	**Health Status or Cause of Death**
Grandmother (Mom's)	☐	☐		
Grandfather (Mom's)	☐	☐		
Grandmother (Dad's)	☐	☐		
Grandfather (Dad's)	☐	☐		
Mother	☐	☐		
Father	☐	☐		
Sister / Brother #1	☐	☐		
Sister / Brother #2	☐	☐		
Sister / Brother #3	☐	☐		

OHIOHEALTH NEUROLOGICAL PHYSICIANS

REVIEW OF SYSTEMS

Patient Name: _____ **Date:** _____

Please circle each item "YES" or "NO" as they pertain to your current health.

GENERAL			RESPIRATORY			ENDOCRINE		
Weight gain	Yes	No	Cough	Yes	No	Heat Intolerance	Yes	No
Weight loss	Yes	No	Shortness of breath	Yes	No	Cold Intolerance	Yes	No
Fatigue	Yes	No	Wheezing	Yes	No	Excessive Thirst	Yes	No
Fever	Yes	No	Excessive Snoring	Yes	No	Excessive Hunger	Yes	No
Chills	Yes	No	Coughing up blood	Yes	No			
Night Sweats	Yes	No						
Insomnia	Yes	No						
Excessive Sleeping	Yes	No						

EYES			MUSCULOSKELETAL			NEUROLOGIC		
Blurred Vision	Yes	No	Muscle Aches/Pain	Yes	No	Difficulty Walking/Falls	Yes	No
Double Vision	Yes	No	Joint Pain/Swelling	Yes	No	Headache/Migraine	Yes	No
Light Sensitivity	Yes	No	Muscle Cramps	Yes	No	Dizziness/Vertigo	Yes	No
Eye Pain	Yes	No	Muscle Weakness	Yes	No	Fainting	Yes	No
			Neck Pain	Yes	No	Difficulty with Speech	Yes	No
			Back Pain	Yes	No	Weakness	Yes	No
						Tingling/Numbness	Yes	No
						Tremors	Yes	No
						Memory Problems	Yes	No
						Seizures	Yes	No
						Difficulty Swallowing	Yes	No
						Altered Taste	Yes	No

CARDIOVASCULAR			GASTROINTESTINAL			PSYCHIATRIC/COGNITIVE		
Chest Pain	Yes	No	Nausea/Vomiting	Yes	No	Depression	Yes	No
Shortness of breath	Yes	No	Constipation	Yes	No	Anxiety	Yes	No
Palpitations	Yes	No	Diarrhea	Yes	No	Hallucinations (auditory or visual)	Yes	No
			Bloody Stools	Yes	No	Problems Concentrating	Yes	No

GENITOURINARY			EAR, NOSE, THROAT			IMMUNOLOGIC		
Frequent Urination	Yes	No	Hearing Loss	Yes	No	Seasonal Allergies	Yes	No
Incontinence	Yes	No	Earache	Yes	No	Hives and/or Rashes	Yes	No
Blood in Urine	Yes	No	Ringing in Ears	Yes	No			
Urinary Infections	Yes	No	Facial Pain	Yes	No			
Changes in Sex Drive	Yes	No	Chronic Congestion	Yes	No			

Reviewed By: _____ **Date:**_____

OhioHealth Physician Group, Neuroscience

New Patient Cancellation and No Show Information

Thank you for choosing OhioHealth Physician Group, Neuroscience for your healthcare needs. We are glad you have made an appointment with our office and look forward to being a partner in your care.

Appointments in our practice are in high demand, and it is important for you to keep all scheduled appointments. If you are unable to keep your scheduled appointment, please notify our scheduling department at 614-533-5500, as soon as possible as this will allow us to schedule other patients who are waiting to be seen.

Our office will call and remind you of your appointment; however, it is your responsibility to keep a record of your appointment and to arrive on time. Patients who cancel appointments with less than **8 hours' notice will be considered a No Show.** New patients that no show two (2) or more scheduled appointments, with the same provider, in a rolling calendar year may not be eligible to reschedule with that provider.

We realize that emergencies may occur and you may not always be able to notify us promptly. If this is the case, it is important for you to communicate with us once your emergency has resolved.

> **After One (1) No Show:** We will send a no-show letter to your primary address to notify you of the missed appointment.
>
> **After Two (2) No Shows:** We will send a notification of the second no-show to your primary address and to your referring provider. New patients that no show (2) or more scheduled appointments, with the same provider, in a rolling calendar year will not be eligible to reschedule with that provider.

Thank you for partnering with us to ensure we serve all of our patients in the best possible way.

Dear Patient ~

If you have had any imaging (CT, MRI, x-rays) done prior to your appointment, please make sure you bring the **"actual" CD** of the imaging with you to your appointment. The physician will not be able to do an assessment with just the report which may result in your appointment needing to be rescheduled. You can obtain these from the facility that performed the test.

If your imaging was done at an OhioHealth facility within Central Ohio, we will have access to those images and you will not need to bring a CD with you. If your imaging was done at an OhioHealth facility in Mansfield, we may not have access to those images and you will need to bring your CD with you.

If you have any questions, please contact us at (614) 533-5500.

Thank you