



**PATIENT REGISTRATION FORM**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Cell Phone#: \_\_\_\_\_ Marital Status: \_\_\_\_\_  Male  Female

Email: \_\_\_\_\_

**POLICY HOLDER INFORMATION—ONLY IF NOT PATIENT:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Cell Phone#: \_\_\_\_\_ Marital Status: \_\_\_\_\_  Male  Female

Relationship to patient: \_\_\_\_\_

**EMPLOYMENT INFORMATION:**

Employer: \_\_\_\_\_ Office Telephone: \_\_\_\_\_

Occupation: \_\_\_\_\_

**PRIMARY INSURANCE:**

Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**SECONDARY INSURANCE (IF APPLICABLE):**

Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**EMERGENCY NOTIFICATION/ NEXT OF KIN**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Dr. Allende and/or staff may discuss my medical condition with the following people:**

1) \_\_\_\_\_ Relationship: \_\_\_\_\_

2) \_\_\_\_\_ Relationship: \_\_\_\_\_

3) \_\_\_\_\_ Relationship: \_\_\_\_\_

**RELEASE OF INFORMATION/ ASSIGNMENT OF BENEFITS**

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of medical benefits directly to my physician. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that regardless of my insurance status I am responsible for any balance of my account.

**PATIENT SIGNATURE OR RESPONSIBLE PARTY SIGNATURE**

**DATE**



PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Rafael Allende, M.D.  
Neurosurgeon

**PATIENT CONSENT AND AUTHORIZATIONS**

**CONSENT FOR TREATMENT:** I, the undersigned patient, parent, or legal guardian, do hereby present to myself (or the patient) for care and treatment at The Neurohealth Sciences Center and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and or surgical procedures. I understand that I am under the care and supervision of my physician and it is the responsibility of the practice and its staff to carry out the instructions of such physician. I understand that the physician furnishing services to me is an employee of the hospital, however, other services such as radiology, laboratory, and pathology may be provided by independent practitioners. All physicians expect payment in full upon receipt of a bill I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcome of care or treatment if I do not follow the care, service, or treatment plan.

**ASSIGNMENT OF BENEFITS:** I hereby assign payment directly to The Neurohealth Sciences Center, and the physician accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to The Neurohealth Sciences Center and their physician for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

**RELEASE OF MEDICAL INFORMATION:** I, the undersigned patient, parent, or legal guardian, do hereby authorize The Neurohealth Sciences Center, its officers and employees, to release to any third party payor (such as an insurance company or government agency; Example: Blue Cross/Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AIDS related complex) treatment information and records, in accordance with the policy of The Neurohealth Sciences Center and any applicable State or Federal Statutes, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release The Neurohealth Sciences Center from all liability that may arise from the release of the information requested.

**FLORIDA LAW:** Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**FOR MEDICARE AND MEDICAID PATIENTS ONLY-CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION**

**AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or/ Title XIX of the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to The Neurohealth Sciences Center physician(s). I understand that I am responsible for any health insurance deductibles and coinsurance.

**MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES:** Medicare does (initials) not cover some inpatient, outpatient, and emergency services. Items not covered include, but not limited to, medications typically self-administered, annual testing and physicals.

**ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE(FOR MEDICARE PATIENTS ONLY):** My signature only acknowledges my receipt of this message from The Neurohealth Sciences Center as dated below and does not waive any of my right to request a review or make me liable for any payment.

**I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH MAYBE ON FILE AT THE NEUROHEALTH SCIENCES CENTER.**

**FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to the account of The Neurohealth Sciences Center physician(s) in accordance with the regular rates and terms of the physicians(s). the undersigned will pay all costs and expenses including reasonable collection fees(which may include agency, attorney, interest or court fees) incurred or paid by the hospital or The Neurohealth Sciences Center in collection of this obligation by suit or otherwise. Furthermore, I hereby authorize and appoint the administrator of Central Florida Regional Hospital and/or The Neurohealth Sciences Center and/or its physician(s) or its successor designee as my attorney-in-fact to take measures in my behalf as may be necessary to collect such claims or insurance proceeds and to endorse any checks made payable to me for such claims or insurance proceeds by signing m) name as attorney-in-fact for me to any such checks and or insurance forms.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Patient's representative/policy holder or spouse  
Indicate relationship: \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Patient unable to sign due to: \_\_\_\_\_



Rafael Allende, *M.D.*  
Neurosurgeon

## OFFICE POLICIES

**In an effort to clarify office policies for our patients, please read and understand the following policies. Hopefully this will reduce concerns and anxieties about your medical care in this practice.**

- 1. Please allow us at least 48 -72 hours for prescription refills. They will only be filled Monday - Friday between 8:30 a.m. - 5:00 p.m. For prescriptions to be refilled you must have been seen within the year.**
- 2. A charge of \$25.00 will apply for all Disability forms to be completed. Please allow us 7 -10 days to complete.**
- 3. Request from Patients for letters in regards to work, insurance, or other matters will take at least 5 - 10 days to complete.**

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Rafael Allende, *M.D.*  
Neurosurgeon

**Acknowledgement of Receipt**

**By sign this Written Acknowledgement of receipt of Rafael Allende, M.D. notice of Privacy Practices (Acknowledgement). I here-by expressly acknowledge my receipt of Healthcare Partners, Notice of Patient Privacy Practices.**

\_\_\_\_\_  
**Patient or Legal Representative Signature**

**Date:** \_\_\_\_\_

**Please Print Name:**

\_\_\_\_\_

**Acknowledgement not obtained because:**

**Patient or legal representative declined notice of patient privacy practices.**

**Other (briefly explain)**

\_\_\_\_\_

**Employee Signature:** \_\_\_\_\_

**Employee's Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_



THE  
NEUROHEALTH  
SCIENCES CENTER, LLC

Rafael Allende, *M.D.*  
Neurosurgeon

Patient Name:	Date of Birth:
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### Section V

Is this visit related to an injury due to a fall?  No  Yes

If Yes, did the accident occur in  your home  public location  other

Date of Accident: \_\_\_\_\_ (**Claim must be filed with responsible party.**)

Is this visit related to an illness/injury due to automobile accident?  No  Yes

If Yes: Date of accident: \_\_\_\_\_

### Section VI

Indicate which statements apply to you.

- I am entitled to Worker's Compensation for this service
- I am entitled to Black Lung benefits.
- I am entitled to VA benefits.
- I am entitled to ESRD benefits.
- I am entitled to COBRA benefits.
- I am entitled to other federal benefits. (UMWA, Government research programs, Hospice) Please explain:

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Neurosurgeon

**PATIENT SELF DETERMINATION ACT  
QUESTIONNAIRE**

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions:

**Declaration to Decline Life-Prolonging Procedure also known as a Living Will**

- I have made such a declaration.
- I have **NOT** made such a declaration.

**Health Care Surrogate**

- I have designated a Health Care Surrogate.
- I have **NOT** designated a Health Care Surrogate.

**Durable Power of Attorney**

- I have appointed a Durable Power of Attorney for Health Care decisions.
- I have **NOT** appointed a Durable Power of Attorney for Health Care decisions.

If you have the above documents, please provide us with a copy.

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Signature of Patient or Representative

# NeuroHealth Sciences Center

## New Patient Information Sheet

Rafael Allende, MD

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Please describe the reason for your visit: \_\_\_\_\_

### Symptoms:

When did symptoms begin: \_\_\_\_\_

When does the pain/problem occur (i.e.: morning/night): \_\_\_\_\_

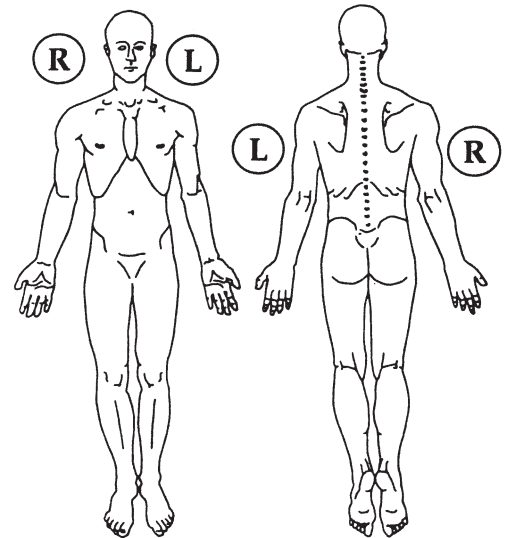
What aggravates the symptoms: \_\_\_\_\_

What reduces the symptoms: \_\_\_\_\_

### Place check if you have other symptoms:

Symptom	Occurrence	Location
Numbness	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
Pins/Needles/Tingling	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
Sharp Pain	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
Dull/Achy Pain	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	

### Shade the areas you have pain



### Rate Your Pain

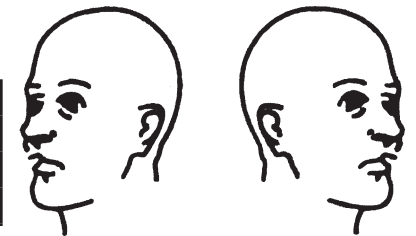
Pain Scale: 0 = No Pain 10 = Worse Pain

Today: \_\_\_\_\_ Past Week: \_\_\_\_\_

### Please check current or previous therapy:

Types of Therapy	Effect on your Symptoms	Month/Year
Physical Therapy	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change	
Nerve Blocks	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change	
Medication Use	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change	
Chiropractor	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change	
Other	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change	

DISABILITY STATUS	Yes	No	Type
Are you currently on disability?			
Have you applied for disability?			
Last Day you worked:			



### Is this injury a result of?

Motor Vehicle Accident?  Yes  No

Work Related Injury?  Yes  No

Date of Injury: \_\_\_\_\_

If yes, to either of the above, explain how injury occurred:

**ALLERGIES:**  None

List all known allergies to medication, food, or latex

NAME OF MEDICATION/FOOD/LATEX	TYPE OF REACTION

**CURRENT MEDICATION:**  No Medications

List all medications you are taking

(Include over the counter, vitamins, and herbs)

NAME OF MEDICATION	DOSE/MG	FREQUENCY

NAME OF MEDICATION	DOSE/MG	FREQUENCY

**MEDICAL HISTORY:**

List all medical problems for which you are currently being treated (high blood pressure, diabetes, Heart)

MEDICAL PROBLEM

MEDICAL PROBLEM

**SURGICAL HISTORY:**  No Hospitalization

List all surgical procedures or major hospitalizations and year of occurrence.

Year	REASON FOR HOSPITALIZATION

Year	REASON FOR HOSPITALIZATION

**FAMILY HISTORY:**

List pertinent family history (diabetes, heart disease, cancer, etc)

PARENTS	AGE	LIVING	DECEASED	MAJOR ILLNESS/CAUSE OF DEATH
Father				
Mother				
<b>SIBLINGS</b>				

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_ If retired, list previous occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Marital Status:

Single  Married  Divorced  Widowed    Number of Children: \_\_\_\_\_

Who do you live with? \_\_\_\_\_

Highest grade of school completed:

Elementary  High School  College  Post Graduate

Alcohol Use:  None

Amount: \_\_\_\_\_ per  Day  Week  Month  Year

Tobacco Use:  None

\_\_\_\_\_ Packs/Cigars per day for \_\_\_\_\_ # of years.    Quit smoking \_\_\_\_\_ years ago.

Street Drug Use:  None

Type: \_\_\_\_\_    Frequency: \_\_\_\_\_ days/weeks/months.    Date of last use: \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please place check if you have or have had problems related to the following systems.

General		Comments	Genitourinary		Comments
<input type="checkbox"/>	Unexplained Weight Loss		<input type="checkbox"/>	Incontinence/Retention	
<b>Eyes/Ears</b>			<input type="checkbox"/>	Prostate Enlargement	
<input type="checkbox"/>	Double/Blurred Vision		<b>Musculoskeletal</b>		
<input type="checkbox"/>	Hearing Loss		<input type="checkbox"/>	Arthritis/Location	
<input type="checkbox"/>	Cataracts		<b>Endocrine</b>		
<b>Pulmonary</b>			<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Asthma		<input type="checkbox"/>	Thyroid	
<input type="checkbox"/>	COPD/Emphysema		<b>Hematological</b>		
<input type="checkbox"/>	Sleep Apnea		<input type="checkbox"/>	Blood Clots	
<input type="checkbox"/>	Pneumonia in past year		<input type="checkbox"/>	Hemophilia	
<input type="checkbox"/>	Shortness of Breath with exertion		<input type="checkbox"/>	Von Williebrands Disease	
<b>Cardiovascular</b>			<b>Neurological</b>		
<input type="checkbox"/>	High Blood Pressure		<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	Heart Attack		<input type="checkbox"/>	TIA/Stroke	
<input type="checkbox"/>	Pacemaker/AICD		<b>Psychiatric</b>		
<input type="checkbox"/>	Valve Disease		<input type="checkbox"/>	Depression/Anxiety	
<input type="checkbox"/>	Chest Pain		<b>Other</b>		
<input type="checkbox"/>	Congestive Heart Failure		<input type="checkbox"/>		
<b>Gastrointestinal</b>			<b>Cardiac/Pulmonary Testing</b>		
<input type="checkbox"/>	Heart Burn/Indigestion/Reflux		<input type="checkbox"/>	Stress Test	
<input type="checkbox"/>	Bowel Incontinence		<input type="checkbox"/>	Heart Angiogram	
<input type="checkbox"/>	Liver Disease/Hepatitis		<input type="checkbox"/>	Echocardiogram	
<input type="checkbox"/>	Ulcers		<input type="checkbox"/>	Pulmonary Function Test	

Date: \_\_\_\_\_

Person Completing Form (please print): \_\_\_\_\_ Signature: \_\_\_\_\_