Crown Point Healthcare Plaza
9235 Crown Crest Blvd., #200
Parker, CO 80138

Limelight Healthcare Center
4350 Limelight Ave., #250
Castle Rock, CO 80109

Dry Creek Medical Campus
125 Inverness Dr. East, #330
Englewood, CO 80112

**Phone (303) 840-5051 Fax (303) 840-5058**

Appointment Date:__________________ Check In________________ Provider:________________

Please make sure to bring the following (not all may apply to your visit):

___ Completed Paperwork (Must be completed prior to arrival or your appointment may be rescheduled)
___ Insurance Card(s), Prescription card and Photo ID
___ Co-Pay if required (We prefer Credit, Debit, or Cash.)
___ If your Insurance plan has a deductible that has not been met at the time of your appointment, you will be expected to pay a portion of that at the time of check-in.
___ Reports AND Discs for Imaging (i.e., MRI, CT, EEG and PET scans) and lab work if applicable.

___ If your insurance is ***AARP Medicare Complete Secure Horizons or an HMO product,*** a referral from your primary care provider is required. This is the patients' responsibility to obtain. If seen without this, patient will be responsible for payment.

******There are many plans within each insurance company. It is impossible to know if we are contracted with all plans. We highly encourage patients to call their insurance ahead of time to verify if we are in network. If you have any questions about this process, please call our office.

If you have any questions or concerns, please feel free to call us at 303-840-5051.

Thank you

Neurology of the Rockies, L.L.C.

**Patient Demographic** Date: ________________

Full Name: ______________________________________ Date of birth: _______________________ Age: ________

Address: ________________________________________ Marital Status:____________ Gender: __ Female __Male

City:______________ State:_____ Zip Code:___________ Occupation: _____________________________________

Home Phone:_______________________________________ Height______ Weight______

Cell Phone:_______________________________________ Please circle: Right or Left Handed

Email:___________________________________________

**Preferred Pharmacy Name, Address, and Phone number:**

________________________________________________

Emergency/Alternate Contact:_______________________

Relationship to you:_______________________________

**Primary Insurance** _____________________________________Policy/Member ID # _______________________________

Group # ________________________________________ Subscriber Name__________________________________________

Relationship __________________ SS# _________________________________Subscriber's Date of Birth _________________

**Secondary Insurance** ____________________________________________ Policy # _________________________________

Group # ________________________________________ Policy Holder Name_______________________________________

Relationship __________________ SS# _________________________________ Subscriber's Date of Birth ________________

**Are you being treated related to a WORKER'S COMP INJURY? Please circle YES OR NO**

**Are you being treated related to a MOTOR VEHICLE ACCIDENT OR LEGAL PROCEEDING?**

**Please circle YES OR NO**

**Primary Care Physician** ____________________________________________ Phone_________________________________

Address___________________________________________________________Fax___________________________________

**Referring Physician:** ____________________________________________ Phone_________________________________

Address___________________________________________________________Fax___________________________________

**RELEASE OF MEDICAL RECORDS**

I hereby authorize the release of my medical records to myself and any physicians listed below:

______________________________________________________________________________________________

Initial

**Consent to Disclose Personal Health Information**

May we leave a voice mail message about your health on any phone number you listed above _____ Yes _____ No

List names and relationship of those you authorize us to discuss your medical care with:

______________________________________________________________________________________________

______________________________________________________________________________________________

**Patient or patient representative signature** **Date**

**Medical / Health History:** Please attach additional sheets of history if needed to include all prior medical, surgical history and current medication list.

**History of your present illness/reason for your visit with the office**

**Current medications you are taking - Include Dosage and Times.**

**List other medications previously tried for your neurologic problem**

**Are you allergic to any medications?**

____ No ____ Yes If yes, Please list all drug allergies

**Past medical history; List any current or past medical conditions, injuries, operations, hospitalizations.**

______________________________ ______________

**Patient or patient representative signature** **Date**

**Past Medical Procedures or Imaging**
**Please note the procedures you have had completed in the last 3 years and the name of the facility:**

MRI________________________________________

CT (CAT) SCAN________________________________________

SLEEP STUDY ________________________________________

EEG________________________________________

EMG (Nerve Conduction Study) ________________________________________

LAB WORK________________________________________

**Family History** **Please select and specify which family member was diagnosed with the following illness**

Migraine____________________ Stroke ____________________ Parkinson's Disease____________________

Seizure ____________________ Other ____________________

**Social History**

Employment______________________________ Years of education_______

Prior Tobacco Use YES NO Current Tobacco Use YES NO If yes, how much & how long____________

Alcohol drinks per week __________ Caffeinated drinks per week__________

Recreational drug use YES NO If yes, what & how long: ____________________

**REVIEW OF SYMPTOMS: Have you had any of the following?**

| Symptom | |
|---|---|
| Chills | |
| Fever | |
| Blurred Vision | |
| Eye Pain | |
| Ear Pain | |
| Diminished Hearing | |
| Ringing in ears | |
| Dizziness | |
| Chest pain | |
| Palpitations | |

| Symptom | |
|---|---|
| Cough | |
| Shortness of Breath | |
| Nausea | |
| Gastrointestinal Problems | |
| Vomiting | |
| Urinary Incontinence | |
| Frequent Urination | |
| Back Pain | |
| Muscle Aches | |

| Symptom | |
|---|---|
| Easy Bruising | |
| Excessive Bleeding | |
| Temperature Intolerances | |
| Excessive Sweating | |
| Anxiety | |
| Depression | |
| Sleep Disturbance | |
| Suicidal Thoughts | |
| | |

Other symptoms you may want to mention or expand upon:

________________________________________

______________________________ __________

**Patient or patient representative signature** **Date**