

WELCOME

TULSA NEUROLOGY CLINIC is pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can.

Patient Name: _____ SS # _____
Last First MI

Date of Birth: _____ Sex: Male Female Height: _____ Weight: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Spouse Name: _____ Spouse SS # _____ Spouse DOB: _____

Home Address: _____
Street City State Zip

Patient Occupation/Employer Name & Address: _____

IN CASE OF EMERGENCY, CONTACT: _____ Relationship _____

Phone #'s of emergency contact: Home _____ Cell _____ Work _____

Financial & Insurance Information

Person responsible for payment of account: Self Spouse Other: _____

Name, Address & Phone (if not listed above) _____

Copy of Insurance Card(s) Primary Insurance _____ Secondary _____

Co-Pay (Specialist)\$ _____ Annual Deductible \$ _____ Met? Yes No Not Sure

Our office is happy to file your insurance as a convenience to you. However it is very important that you realize that ultimately, payment of fees is the patient's responsibility. Co-Pays are collected at the time of the visit. Deductibles are a contractual obligation that you are legally required to meet under the terms of your insurance.

I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered.

Assignment of benefits: I authorized payment of medical benefits to be paid directly to Tulsa Neurology Clinic.

I hereby give permission to JAY K. JOHNSON, D.O. to administer treatment & perform such procedures as may be necessary in the diagnosis or treatment of my neurologic condition. I also authorize and request you to release complete medical records concerning my illness and treatment to the physicians that have been/are/will be involved in my care.

Patient/Guarantor Signature **X** _____ Date _____

PATIENT HISTORY (Please Print)

Patient Name:	First _____	Middle _____	Last _____	Age _____	Sex M <input type="checkbox"/> F <input type="checkbox"/>
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Medical Allergies None **If you have allergies, please list the type of reaction you have when taking the medication**

Name of Medication	Type of Reaction	Name of Medication	Type of Reaction

Past Medical History: Please below under the "yes" column or "no" column to indicate any problems you have had in the past.

G	YES	NO		G	YES	NO		OB History	Life Style
GENERAL	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	GI	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pain	# of Pregnancies _____ # Live Births _____ # Abortions _____	Height _____ Usual Weight _____ lb Weight Change in past Year: Gained _____ lb Lost _____ lb
	<input type="checkbox"/>	<input type="checkbox"/>	Weakness		<input type="checkbox"/>	<input type="checkbox"/>	Constipation		
	<input type="checkbox"/>	<input type="checkbox"/>	No Appetite		<input type="checkbox"/>	<input type="checkbox"/>	Loose Stools		
	<input type="checkbox"/>	<input type="checkbox"/>	Chills/Sweats		<input type="checkbox"/>	<input type="checkbox"/>	Change in Bowels		
	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Difficulty		<input type="checkbox"/>	<input type="checkbox"/>	Black Stools		
	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Fever		<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools		
<input type="checkbox"/>	<input type="checkbox"/>	Bleeds Easily							
HEAD	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headache	GU	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	Operations (show year) <input type="checkbox"/> None <input type="checkbox"/> Tonsils <input type="checkbox"/> Appendix <input type="checkbox"/> Gallbladder <input type="checkbox"/> Hernia <input type="checkbox"/> Abdomen <input type="checkbox"/> Heart <input type="checkbox"/> Lungs <input type="checkbox"/> Breast or female organs <input type="checkbox"/> Eyes	How many meals do you Eat daily? _____ Do you exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes (list type)
	<input type="checkbox"/>	<input type="checkbox"/>	Migraines		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Holding Urine		
	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy Spells		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Starting Urine		
	<input type="checkbox"/>	<input type="checkbox"/>	Fainting		<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination		
EYES	<input type="checkbox"/>	<input type="checkbox"/>	Wears Glasses	NERVOUS	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	Medication & Supplements (List all you take including herbs) <input type="checkbox"/> None <input type="checkbox"/> See Attached List Aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No Ibuprofen? <input type="checkbox"/> Yes <input type="checkbox"/> No Calcium? <input type="checkbox"/> Yes <input type="checkbox"/> No Vitamins? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco: <input type="checkbox"/> Dip / Chew <input type="checkbox"/> Cigars <input type="checkbox"/> Cigarettes Packs per day _____ # of Years _____ Years Stopped _____
	<input type="checkbox"/>	<input type="checkbox"/>	Major Vision Change		<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones		
	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision		<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy		
	<input type="checkbox"/>	<input type="checkbox"/>	See Double		<input type="checkbox"/>	<input type="checkbox"/>	Dizziness		
EARS	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain/Itching	BONES	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	Medication Dose	Caffeine: Cups per day _____ Alcohol: <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy
	<input type="checkbox"/>	<input type="checkbox"/>	Earache		<input type="checkbox"/>	<input type="checkbox"/>	Can't Make Decisions		
	<input type="checkbox"/>	<input type="checkbox"/>	Drainage		<input type="checkbox"/>	<input type="checkbox"/>	Memory Problems		
	<input type="checkbox"/>	<input type="checkbox"/>	Noise in Ears		<input type="checkbox"/>	<input type="checkbox"/>	Depressed/Feel Sad		
NOSE	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Hearing	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	Considered Suicide	Have you ever used illegal or street drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes (list type)	
	<input type="checkbox"/>	<input type="checkbox"/>	Earache		<input type="checkbox"/>	<input type="checkbox"/>	Lost Consciousness		
	<input type="checkbox"/>	<input type="checkbox"/>	Drainage		<input type="checkbox"/>	<input type="checkbox"/>	Excessive Fear		
	<input type="checkbox"/>	<input type="checkbox"/>	Noise in Ears		<input type="checkbox"/>	<input type="checkbox"/>	Aching Joints		
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Aching Muscles		
THROAT	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	FAMILY	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps	Has anyone in your immediate Family had any of the following? YES NO <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Heart Attack <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Cancer Site _____ <input type="checkbox"/> <input type="checkbox"/> Mental Illness <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> <input type="checkbox"/> Neurologic Diseases such as Migraine, Alzheimer's	
	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing		<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain		
	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble		<input type="checkbox"/>	<input type="checkbox"/>	Painful Feet		
	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever		<input type="checkbox"/>	<input type="checkbox"/>	Polio		
	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds		<input type="checkbox"/>	<input type="checkbox"/>	Pain in Arms		
LUNGS & HEART	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	HX	<input type="checkbox"/>	<input type="checkbox"/>	Numbness Arms/Legs	Medication Dose	
	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Feet/Ankles		<input type="checkbox"/>	<input type="checkbox"/>	Highs Cholesterol		
	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain		<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		
	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack		<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst		
	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmurs		<input type="checkbox"/>	<input type="checkbox"/>	Cancer Site _____		
GI	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	Fall & Assist Devices			Do you use or have installed any of these devices or equipment? Quad Cane <input type="checkbox"/> Yes <input type="checkbox"/> No Walker <input type="checkbox"/> Yes <input type="checkbox"/> No Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No Shower Bars <input type="checkbox"/> Yes <input type="checkbox"/> No Raised Toilets <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion						
	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers						
	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Nausea						
	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting						
	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood						
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing							
Education Completed									
<input type="checkbox"/> Grade <input type="checkbox"/> High <input type="checkbox"/> Business/Vocational <input type="checkbox"/> College									
Occupation(s):									
<input type="checkbox"/> Retired									

Physician Signature _____

NEUROLOGY
Jay K. Johnson, D.O.

Board Certified
Neurology

Neuroimaging
Electrodiagnosis

Policy for Failed Appointments and Cancellations

As with most specialists, our practice has a waiting list. We know you appreciate being seen as quickly as possible, so please let us know when you can not make your appointment so that someone else may utilize that time.

We try to be understanding and rarely do charge for missed appointments, but it is important that you understand our cancellation policy and the fact that we may charge for missing your scheduled time.

Failed Appointments:

- No-Show, no-call or inadequate reason for missing
- Late without ability to work-in or refusal to wait
- Failure to cancel 24 hrs prior to appointment

Cancellation Policy: Must call in person, leave message, or fax within 24 hours of appointment.

Charges for Failed Appointments: Initial Consultation- \$285 fee
Follow Up Visit- \$50 fee

These charges are not covered by insurance and are billed directly to the patient.

Discharge: We are concerned about your healthcare and wish to continue providing for your care at your request; however, if you have 3 or more failed appointments without proper notice we do reserve the right to dismiss you from care in our office.