



Pamela L. Vincent MD, P.C. – Riverwoods Neurological Center

Established Patient History & Clinic Policies

To our patients; we appreciate the opportunity to be involved in your health care. Please help us provide excellent and efficient care by filling out this information form as completely as possible. If you are waiting for longer than 30 minutes after turning in your history forms, we apologize and please let the receptionist know.

Additional information you should know to help us provide the best medical care:

- 1. Co pays / deductibles are always due at the time of service.**
- 2. Please be prepared to provide current insurance information at each visit.**
3. Always bring a current list of your medications to your appointment and give it to the receptionist.
4. Medication refill requests can be left on the phone messaging service; we will generally call in refills after clinic hours; please allow at least 24 hours for refills.
5. Refill requests must be called in before noon on Friday to be filled before the following Monday.
6. Pain medication such as narcotics cannot be refilled early and cannot be refilled by the doctor on call.
7. Please be very careful not to run out of essential medications, such as seizure medications.
8. We rely on you to keep your scheduled appointments. You will be charged \$35 for a missed appointment unless you notify us 24 hours in advance. This will be your responsibility, your insurance will not be charged. If you miss 3 appointments, we will not be able to reschedule another appointment.
9. If you are asked to keep a symptom diary, obtain medical records, bring in test results, such as MRI scans, please remember to do so.
10. Our association with Integrated Healing Arts-Utah allows us to offer complementary and alternative approaches to management of some medical problems; if this is of interest to you, please request referral or more information.
11. Please let us know how we can better serve you and meet your expectations.

Thank you
Pamela Vincent, MD
And Staff

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Tel (801) 229-1014

PATIENT REGISTRATION UPDATE

Patient Name _____ D.O.B. _____

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ E-Mail Address _____

Marital Status M S D W Employment Status FT PT Not Employed

Employer Name / Address / Phone _____

Referring Doctor _____ Primary Care Doctor _____

Has your insurance changed since your last visit? Yes No

If yes, please indicate which insurance changed: Primary Secondary

PLEASE ENTER NEW INSURANCE INFORMATION BELOW

New Insurance Company Name _____

Insurance Address _____

Insurance Phone Number _____

Name of Insured _____ D.O.B. _____

Insured ID# _____ Group # _____ Effective Date _____

Employer's Name / Address / Phone _____

Relationship of insured to the patient: Self Spouse Child Other

ASSIGNMENT OF BENEFITS / AUTHORIZATION FOR TREATMENTS: I certify the above information to be true and correct. In signing, I understand that I am updating the patient information sheet already on file and are under the same financial obligations that are stated in the original registration form. I/We hereby assign and transfer to Pamela Vincent, MD all insurance benefits payable to me/us by my/our insurance company(s), listed on this form, for the services and costs incurred in connection with treatment. I/We authorize payment of such benefits to be made by said insurance company(s) directly to Pamela Vincent, MD. I/We also authorize the release of any medical record information necessary to process any and all insurance claims.

Patient or Authorized Representative

Date

Neurological Center Established Patient History Form

Patient Name _____

Reason for visit _____

Date of last visit _____

Referring doctor _____ Primary care doctor _____

Current Medications:

Please list any recent medical condition changes or prescription medicine changes:

Have you recently had any of the following tests:

TEST	WHERE	DATE
BLOOD WORK		
CT / MRI		
EEG		
EMG		
TEE		
OTHER		

COMMENTS _____

Review of Systems: Circle any positives and give details.

General: fever, sweats, weight loss / gain, fatigue, swelling _____

Skin: _____

HEENT : _____

Eyes: Vision Change

Ears, nose, throat, tinnitus, vertigo, allergies

Neck / Back: pain, stiffness _____

Respiratory: asthma, cough, shortness of breath, sleep disorder

Breast pain, mass, nipple discharge

Cardiovascular: chest pain, syncope / fainting, hypertension

Gastrointestinal: abdominal pain, change in bowel habits, nausea, vomiting

Genitourinary: UTI, urinary incontinence, pelvic pain, blood in urine, change in urinary stream.

Musculoskeletal: joint pain, joint stiffness, muscle pain or weakness

Neurological: cognitive dysfunction, difficulty with speech or swallowing, numbness or tingling, focal weakness, headaches, tremor, dizziness, vertigo, seizures

Psychiatric: depression, anxiety, mood swings

Endocrine: thyroid, diabetes, heat or cold intolerance, hair loss, excessive thirst.

Heme / blood disorders, bruising: _____

Other: FMS _____ CFS _____

Allergies to Medications? Yes No

Please give details _____

Have you traveled out of the area recently? Where _____

Have you had any known exposure to toxins, insect bites, or sick people? _____