The Ben and Catherine Ivy Center for Advanced Brain Tumor Treatment
Registration Form New Patient ❒ Update ❒

Patient Information

SSN:	Last Name:	First Name:	MI:
Maiden Name:		Emergency Contact: Name/Phone Number	
Street Address:	City:	State:	Zip:
Home Phone:	Alternate Phone:	Date of Birth:	
Gender: ❒ Male ❒ Female	Marital Status: ❒ Divorced ❒ Married ❒ Single ❒ Widowed	Optional: ❒ Smoker ❒ Non-smoker ❒ Previous smoker	Race (optional): ❒ Asian ❒ Hispanic ❒ African Am. ❒ Native Am. ❒ Caucasian
We are collecting this information for demographic research purposes only.			

Employer Information:

Employer Name:			
Street Address:	City:	State:	Zip:
Occupation:	Student Status: ❒ Full time ❒ Part time		

Insurance:

Insurance Company Name:	Relation to Subscriber:	Copay: $	
Subscriber's Name:	Subscriber's Employer:		
Subscriber's D.O.B.:	Subscriber's Gender: ❒ Male ❒ Female	Subscriber's ID:	Group Number:

Secondary Insurance:

Insurance Company Name:	Relation to Subscriber:	Copay: $	
Subscriber's Name:	Subscriber's Employer:		
Subscriber's D.O.B.:	Subscriber's Gender: ❒ Male ❒ Female	Subscriber's ID:	Group Number:

Responsible Party: Who is responsible for the remaining balance on this account?

❒ Self (1) ❒ Parent (3) ❒ Guardian (5)			
SSN:	Last Name:	First Name:	MI:
Street Address:	City:	State:	Zip:
Home Phone: ( ) -	Alternate Phone: ( ) -	DOB:	Gender: ❒ Male ❒ Female
❒ Workers Comp (6)	Claim #:	Date of injury:	
❒ Employer Contract (10)	Employer Name:		

The patient or guarantor(s) certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize the physician and/or clinic to release any information to process insurance claim forms. I also authorize my insurance claim to be paid directly to the clinic.

Patient Signature: ____ Date: ____________________________________

Medical History Form

Name: ______________________ Date: ______________________

DOB: ______________________ Age: __________ Occupation: ______________________

HT: ____________ WT: ____________ Dominant Hand: ❑ Right ❒ Left ❒ Ambidextrous

Reason for this visit: ____

Other Medical Problems:	Past Surgeries:

Have you ever had: ❒ Fever related childhood seizures ❒ Meningitis ❒ Encephalitis ❒ Serious head injury

Allergies:

Tobacco use:	❒ Never	❒ Previously, but quit Date stopped:	❒ Current _______packs per day.

Use of Alcohol:	❒ Daily	❒ Moderately	❒ Rarely	❒ Never

Recreational Drug Use:	❒ Never	❒ Yes	Type/Frequency:

Review of systems: Do you currently have any of the following problems?		*If yes, please explain:*
Neurological problems(i.e. Headaches, stroke, memory loss)	❒ Yes ❒ No	
Eye disease(i.e. glaucoma, cataracts, wandering or lazy eye)	❒ Yes ❒ No	
Chronic Fever, unexpected weight loss, fatigue	❒ Yes ❒ No	
Ear/Nose/Throat problems(i.e. hearing loss, sinus problems)	❒ Yes ❒ No	
Heart problems(i.e. chest pain, irregular heart beat)	❒ Yes ❒ No	
Respiratory problems(i.e. shortness of breath, wheezing)	❒ Yes ❒ No	
Gastrointestinal problems(i.e. heartburn, abdominal pain, diarrhea)	❒ Yes ❒ No	
Urinary problems(i.e. pain, incontinence, blood in urine)	❒ Yes ❒ No	
Endocrine problems(i.e. diabetes, thyroid disease, menstrual problems)	❒ Yes ❒ No	
Psychiatric problems(i.e. depression, anxiety, anger problems)	❒ Yes ❒ No	
Reproductive problems(i.e. pregnancy, prostate problems, impotence, etc.)	❒ Yes ❒ No	

Family medical history: Any immediate family members with a history of either Epilepsy or neurological disease?

❒ Yes ❒ No	Explain:	
		MD initials:

Medical History Form continued:

Referring Provider: Name:	Address:	Phone:
Primary Care Provider: Name:	Address:	Phone:
Legal Next of Kin: Name:	Address:	Phone:
Living Situation: ❑ Live Alone ❒ With Family ❒ With Friends ❒ Homeless ❒ Other		
Date of injury and/or when this problem began:		
Is this injury/problem work related? ❒ Yes ❒ No (if yes, please list claim number and name/number of case manager:		

MRI Information:

A. Do you have any metal implants such as:		
Aneurysm clip(s):	❒ Yes ❒ No	If yes, what year:
Cardiac pacemaker:	❒ Yes ❒ No	If yes, what year:
Neuro-stimulator:	❒ Yes ❒ No	If yes, what year:
Cochlear Implant:	❒ Yes ❒ No	If yes, what year:
SWAN/EPI catheter:	❒ Yes ❒ No	If yes, what year:
Bullets/Bullet fragments:	❒ Yes ❒ No	If yes, what year:
B. Do you have significant claustrophobia: ❒ Yes ❒ No		Will you need sedation: ❒ Yes ❒ No
C. Do you have a previous history of working with metal? (Such as welder, sheet metal worker, etc.) ❒ Yes ❒ No		
D. Are you allergic to IV contrast dye, Iodine or shellfish? ❒ Yes ❒ No		
E. If female, is there a chance that you could be pregnant? ❒ Yes ❒ No		

Medication Record

Patient Name:
Date of Birth:

In order to prevent mistakes with your medications, please transfer the information from the labels on your prescription bottles to this sheet. Accurate information is required for your safety.

Name of Medication (e.g.: Plavix)	Dosage/Strength: (e.g.: 250mg)	Schedule: (e.g.: 1 tablet 2x per day)	Reason for taking this medication: