Welcome Letter

On behalf of our entire staff, I would like to welcome you to Diamond Headache Clinic & Purath Headache & Neurology. Our goal is to exceed your expectations - knowledgeable of the trust you are placing in us. Your care is our #1 priority. In order to get the most out of your care plan you will need to be an active participant. We encourage patients to ask questions if something is unclear and voice concerns when you may disagree with a recommendation. In return we ask that you follow our recommendations and be mindful of the following:

- Our office hours are Monday through Friday 8:00am - 4:30pm
- Clinic telephone: (414) 837-5656
- Clinic fax: (414) 837-5688
- We do not have "on-call" availability
- Please complete the enclosed materials prior to your appointment and bring them with you.
- Bring all currently prescribed and over the counter medications you are taking, a list of previous medications you have tried and any MRI reports/films taken.
- **IMPORTANT: Prescription refill requests can only be accommodated between the weekday hours of 8:00am - 4:00pm. Contact your pharmacy to fax us a refill request. Please be mindful of your refill needs in advance and contact us promptly as the need arises. All requests will be responded to within 48 hours or two business days. We cannot respond to refill requests on the evening or on weekends/holidays.**
- Monday – Friday during non-clinic hours of 4:30PM - 8:00AM and on weekends, please leave a message and your call will be returned on the next clinic day. If it is an emergency and you feel that you cannot wait to speak with someone until the next business day, we suggest that you go to either urgent care or the emergency room.
- We understand that unforeseen circumstances occur. If you are unable to make your appointment, please contact the clinic at least 48 hours prior to your scheduled time. We reserve the right to refuse to reschedule appointments for patients who fail to show up for their first appointment or fail to show up for TWO follow up appointments.
- Please be sure to bring your insurance card and photo id to each appointment.

If you have questions, please ask. We cannot address an issue if we are unaware of its existence. We look forward to serving you.

Sincerely,

Traci A Purath MD

Traci A. Purath, M.D.
Board Certified Neurologist

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www.drtracipurath.com

New Patient Registration Form

PATIENT'S PERSONAL INFORMATION:

Full Name:_____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip: _____

Home phone: (___)_____ Cell phone: (___)_____

E-mail Address: _____

PRIMARY INSURANCE INFORMATION (INSURANCE CARDS MUST BE PRESENTED AT CHECK-IN)

Name of insurance: _____

Name of Insured:_____ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insured Date of Birth:_____ Insured ID #:_____ Group #:_____ Eff. Date: _____

SECONDARY INSURANCE INFORMATION (if applicable):

Name of insurance:_____ Name of Insured: _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other_____ Insured Date of Birth: _____

Insured ID #:_____ Group #:_____ Eff. Date: _____

GUARANTOR INFORMATION:

Name:_____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip: _____

Relationship to patient: _____ Primary Phone Number: (___)_____

EMERGENCY CONTACT:

Name:_____ Relationship: _____

Address:_____ City:_____ State:_____ Zip: _____

Primary Phone Number: (___) _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby give lifetime authorization for payment of insurance benefits to be made directly to the Diamond Headache Clinic & Purath Headache & Neurology, and any assisting physicians, for services rendered. I understand that although an insurance claim has been filed on my behalf, it is not a guarantee of payment, and that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize the Diamond Headache Clinic to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGNATURE: _____ DATE: _____

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Financial Policy

INRODUCTION:

The clinic of Diamond Headache Clinic & Purath Headache & Neurology is a professional business providing health-related diagnostic and therapeutic services to patients with the expectation of making the profit necessary to financially support its employees, to pay its expenses, and to develop future services. Any professional relationship requires honest financial accountability.

At each office visit or encounter, the patient will be asked to provide a current mailing address and telephone number as well as third-party information necessary for billing purposes. This information should be given to a billing representative or receptionist The doctor or nurse will need to know the identity of the insurance company in order to make proper referrals under the managed care contract; thus, proper identification is essential.

CHARGES FOR PROFESSIONAL SERVICIES:

Every professional *service* and associated expense will be charged to the patient according to a fee schedule determined by the Clinic. Contractual discounts to third parties agreed to by the Clinic will be honored in good faith. No fee or charge can be reduced or waived without the permission of the administrator, billing manager, or his or her designee. An estimate of fees can be requested. Monthly statements of payment transactions and the total amount owed will be sent until the debt is satisfied.

INSURANCE:

Health insurance is primarily a contract between the patient and the insurance company; however, the clinic of Diamond Headache Clinic & Purath Headache & Neurology also has mutually agreed contractual obligations with certain private and governmental entities. The patient is primarily responsible for holding the insurance company accountable for claims reimbursement. The clinic of Diamond Headache Clinic & Purath Headache & Neurology will make available substantial resources to facilitate insurance payment and will dedicate its resources toward its own contractual obligations with these entities.

PAYMENT:

Payment for services rendered is due on the date of service and is part of the professional relationship. The clinic of Diamond Headache Clinic & Purath Headache & Neurology reserves the right to request payment of the total fee on the date due unless directed otherwise by contract. Cash, check, money order, and most credit/debit cards will be acceptable methods of payment. **All co-payments and deductibles will be collected at the time of service.** Non-urgent professional services may be delayed or terminated within the guidelines of good medical practice for bad-faith patient noncompliance with this financial policy. Only the administrator, billing manager, or their designated representative can amend this policy.

CREDIT:

Credit will be extended for 60 days to patients with valid insurance policies applicable to the charges for services **after fulfillment of appropriate deductibles and co-payments.** After 60 days all payments are due. The clinic of Diamond Headache Clinic & Purath Headache & Neurology will utilize all reasonable means to collect funds. Defaults in payment of agreed amounts may be referred to a collection agency for payment.

RESPONSIBILITIES OF THE CLINIC:

The Clinic will utilize its best effort to obtain necessary pre-certifications for requested procedures required by contracted third parties to facilitate approval for payment thereof. Failure to obtain pre-certifications or approval from the insurance company does not necessarily mean that the requested procedure is not medically necessary; in this circumstance, the patient may be financially responsible for *services* ordered or rendered. Upon receiving accurate third-party information, the Clinic will file the appropriate approved claim to the appropriate entity. The Clinic will make a good-faith effort in concert with the patient to follow up these claims to facilitate payment.

RESPONIBILITY OF THE PATIENT:

The patient should contact the insurance company and/or third parties for necessary pre-certifications needed for insurance or third-party payment prior to the office visit. A telephone number on the back of the insurance card can usually be used to obtain this information. We ask that patients make total payment when the debt is due.

- We encourage patients to proactively discuss extenuating circumstances with the Clinic.
- The Clinic will uniformly and fairly enforce this policy and procedure.

This office reserves the right to change its fees at any time without prior notice

☐ **I have read, understand and agree with the Clinic Financial Policy**

Name: _____ **Date:** _____

Signature: _____

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Consent for Treatment and Payment Agreement

I hereby authorize Diamond Headache Clinic & Purath Headache & Neurology to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designee may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Diamond Headache Clinic & Purath Headache & Neurology of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records will be stored electronically and made available through computer networks.

Healthcare operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

I have fully read and understand the above payment policy. I agree to forward any payments to Diamond Headache Clinic & Purath Headache & Neurology from any insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare/Commercial Insurance Authorization

I certify that the information given by me in applying for payment under Title *XV II* of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medicare or Commercial Insurance Claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare or my Commercial Insurance for payment.

I assign the benefits payable for services to Diamond Headache Clinic & Purath Headache & Neurology. _____
Initial

Release of Medical Information

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to *leave* the exam room at any time.

Person(s) who is/are authorized to receive information:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

☐ **I have read, understand and agree with the Clinic Financial Policy**

Name: _____ **Date:** _____

Signature: _____

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Medical History Form

FULL NAME: _____ DATE OF BIRTH: _____

Current Medications

Please list all the medications that you are currently taking both for headaches and other reasons.

MEDICATION:	DOSE:	FREQUENCY:	DURATION:

ALLERGY:	REACTION:

Pharmacy

In order for prescriptions to be electronically sent, we require your pharmacy's **address, fax number and phone number.**

PRIMARY PHARMACY: _____ ADDRESS: _____
PHONE NUMBER: _____ FAX NUMBER: _____
TYPE: ☐ LOCAL ☐ MAIL ORDER | MAIL ORDER ID: _____

SECONDARY PHARMACY: _____ ADDRESS: __ PHONE NUMBER: _____
_____ FAX NUMBER: _____
TYPE: ☐ LOCAL ☐ MAIL ORDER | MAIL ORDER ID: _____

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Medical History Form

Previous Medications

The following is a list of medications and treatment options sorted by generic name with the brand name in parentheses. Please **check all** medications and treatment options that you have *tried* for your headaches. Place an **asterisk (*)** on the right-hand side for any medications/treatments that were effective in helping reduce and/or eliminate your headache pain.

Alternative
Acupuncture
Biofeedback
Botulinum toxin type A (Botox) Chiropractic
Facet Blocks
Nerve Blocks
Pain Pump
Trigger Point Injection
Physical Therapy
Meditation
Reiki

Analgesic
butalbital/aspirin/caffeine (Fiorinal)
butorphanol (Stadol)
diclofenac (voltaren, cataflam)
dronabinol (Marinol)
fentanyl (Duragesic, Actiq) hydrocodone (Lorcet, Norco, Vicoden, Tylenol #3, Tylenol #4) hydromorphone (Dilaudid) indomethacin (Indocin)
ketorolac (Toradol)
mefenamic acid (Ponstel)
meloxicam (Mobic)
meperidine (Demerol)
methadone (Dolophine)
morphine (Dadian, Ms Contin)
oxycodone (Oxycontin, Percocet)
propoxyphene (Darvocet)
tramadol (Ultram, Ultracet)

Anti-Anxiety
atarax (Hydroxyzine)
alprazolam (Xanax, Niravam)
buspirone (Buspar)
clonazepam (Klonopin)
clorazepate (Tranxene)
lorazepam (Ativan)
vistaril (Hydroxyzine)

Anti-Convulsant
carbamazepine (Tegretol)
divalproex sodium (Depakote)
gabapentin (Neurontin)
lamotrigine (Lamictal)
levetiracetam (Keppra)
magnesium oxcarbazepine (Trileptal)
pregablin (Lyrica)
tiagabine (Gabatril)
topiramate (Topamax)
zonisamide (Zonegran)

Anti-Depressant
amitriptyline (Elavil) amitriptyline+perphenazine (Triavil) amitriptyline+chlordiazeloxide (Limbitrol)
aripiprazole (Abilify)
buproprion (Wellburtin)
citalopram (Celexa)
desipramine (Normpramin)
desvenlafaxine (Pristiq)
doxepin (Sinequan)
duloxetine (Cymbalta)
escitalopram (Lexapro)
fluoxetine (Prozac)
fluvoxamine (Luvox)
haloperidol (Haldol)
isocarboxazid (Marplan)
lithium (Eskalith, Lithobid)
milnacipran (Savelle)
mirtazapine (Remeron)
modafinil (Provigil)
nefazodone (Serzone)
nortriptyline (Pamelor, Aventyl)
olanzipine (Zyprexa, Zydis)
paroxetine (Paxil)
phenelzine (Nardil)
protriptyline (Vivactil)
quetiapine (Seroquel)
risperidone (Risperdal)
selegiline (Emsam, Zelapar)
sertraline (Zoloft)
venlafaxine (Effexor)
vilazodone (Viibryd)
ziprasidone (Geodon)

Anti-Migraine
almotriptan malate (Axert)
diclofenac (Cambia)
dihydroergotamine (DHE-45, migranal)
eletriptan (Relpax)
ergotamine (Ergomar,Cafergot,Bellergal)
frovatriptan (Frova)
isometheptene mucate (Migraten, Midrin)
lasmiditan (Reyvow)
methylergonovine (Methergine)
naratriptan (Amerge)
rizatriptan (Maxalt)
sumatriptan (Alsuma,Imitrex,Sumavil,Treximе, Tosymra, Zembrace)
sumatriptan +naproxen sodium (Treximet)
ubrogepant (Ubrelvy)
zolmotripten (Zomig)

Blood Pressure
atenolol (tenormin)
bisoprolol (zebeta)
candesartan (atacand)
clonidine (catapres)
diltizaem (cardizem, cartia, tiazac)
enalapril (vasotec)
losartan (cozaar)
metoprolol (Lopressor, torprol xl)
nadolol (corgard)
nebivolol (Bystolic) nimodipine (nimotop) propranolol (Inderal)
verapamil (verelan, calan, isoptin)

CGRP
eptinezumab-jjmr (Vyepti)
erenumab-aooe (Aimovig)
fremanezumab-vfrm (Ajovy)
galcanezumab-gnlm (Emgality)

Devices
Cefaly
gammaCore
Nerivio TMS

Muscle Relaxer
baclofen (lioresal)
carisoprodol (soma)
chlorzoxazone (parafon forte)
cyclobenzaprine (Flexeril)
metaxalone (skelaxin)
orphenadrine (norflex, norgesic forte)
tizanidine (Zanaflex)

Sleep Aids diazepam (Valium) droperidol (inapsine)
eszopiclone (Lunesta)
Melatonin
ramelteon (Rozerem)
trazadone (Desyrel)
zolpidem (Ambien)

Other
atomoxetine (strattera)
cyproheptadine (periactin)
dexamethasone (decadron)
dextroamphetamine (Adderal)
diphenhydramine (Benadryl)
memantine (Namenda)
methylprednisolone (Medrol)
oxygen
prednisone

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Diamond Headache Clinic
Treatment – and beyond

Purath
HEADACHE & NEUROLOGY

Medical History Form

Please answer all questions to the best of your ability. Be assured, that your physician will review the information that you provide in this form during your visit.

FULL NAME: _____ DATE OF BIRTH: _____

Past Medical History

Please check all previous and current medical diagnoses from the list below. If known, please enter the month/year the diagnosis was made after each condition.

- ☐ Abnormal Heart Rhythm
- ☐ Allergy - Seasonal
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Blood Clots
- ☐ Bowel Disease/Disorder
- ☐ Brain Tumor
- ☐ Cancer
- ☐ Cerebrovascular Disease/Stroke
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Lung Disease
- ☐ Chronic Sinusitis
- ☐ C O P D
- ☐ C R F (Chronic Renal Failure)
- ☐ CT of Head/Neck
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Diamond Headache Unit – Previous patient admission
- ☐ Emphysema
- ☐ Endocarditis
- ☐ Endocrinology Disorder
- ☐ Factor V Leiden Deficiency
- ☐ Fibromyalgia
- ☐ Giant Cell Arteritis
- ☐ G E R D
- ☐ G I Bleed
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Human Immunodeficiency Virus
- ☐ Impotence
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Lupus
- ☐ Liver Disease
- ☐ M I (Heart Attack)
- ☐ MRA Head
- ☐ MRI Head
- ☐ MRI Neck/Back
- ☐ Neurologic Disorder
- ☐ Osteoporosis
- ☐ Panic Disorder
- ☐ Patent Foramen Ovale
- ☐ Peptic Ulcer
- ☐ Prostate Disease
- ☐ Pulmonary Embolism
- ☐ Raynaud's Disease
- ☐ Seizure Disorder/Epilepsy
- ☐ Sleep Apnea
- ☐ Suicide Attempt
- ☐ Syncope
- ☐ Temporomandibular Joint Syndrome (TMJ)
- ☐ Thyroid Disorder
- ☐ Urinary Tract Infection
- ☐ Valvular Heart Disease

Past Surgical History

Please check all previous surgeries from the list below. Please enter the month/year the surgery was performed after each condition.

- ☐ Abdominal Surgery
- ☐ Adenoids
- ☐ Amputation
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ C-Section
- ☐ CABG
- ☐ Carotid Endarterectomy
- ☐ Cataract Extraction
- ☐ Chiari Decompression
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ D&C
- ☐ Gallbladder Surgery
- ☐ Gastric Bypass
- ☐ Interventional pain procedures
- ☐ Joint replacement - _____
- ☐ Hysterectomy - partial/total
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Mitral Valve Replace
- ☐ Organ Transplant - _____
- ☐ Pacemaker
- ☐ Parathyroidectomy
- ☐ Pneumonectomy
- ☐ Prostatectomy
- ☐ PTCA
- ☐ Sleep Apnea Surgery
- ☐ Sinus Surgery
- ☐ Tonsillectomy
- ☐ TURP+
- ☐ Urinary Incontinence Surgery
- ☐ Vertebroplasty
- ☐ History of Anesthesia Problems
- ☐ History of Surgical Complications
- ☐ History of Post-operative Complications

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Family History

Please check all of the medical conditions that are related to your family history:

- ☐ Anesthetic Complications
- ☐ Anxiety
- ☐ Asthma
- ☐ Birth Defects
- ☐ Blood Clots
- ☐ Cancer - _____
- ☐ Chronic Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines Mother
- ☐ Migraines Father
- ☐ Migraines Brother
- ☐ Migraines Sister
- ☐ Migraines as a child
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Seizures/Epilepsy
- ☐ Severe Allergies
- ☐ Stroke
- ☐ Substance or Alcohol Abuse
- ☐ Suicide/Suicide Attempt
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Weight Disorder

Social History

Please check all of the following that apply to you.

- ☐ History of Domestic Abuse
- ☐ History of Sexual Abuse
- ☐ History of Physical Abuse
- ☐ History of Verbal Abuse
- ☐ History of Substance Abuse
- ☐ History of Alcohol Abuse
- ☐ Abandoned/orphaned as a child
- ☐ Suicidal Thoughts
- ☐ Suicidal Attempt
- ☐ Recent Loss of a family member or friend
- ☐ Decreased Libido
- ☐ Considers Self Type A Personality
- ☐ Considers Self Type B Personality
- ☐ Recent Increase in Moodiness
- ☐ Recent Increase in Irritability
- ☐ Recent Increase in Anxiety
- ☐ Recent Increase in Depression

Stress

☐Currently Under Extreme Stress

Areas of stress include:

☐Work ☐Marriage ☐Finances ☐Time Management ☐Relationship ☐School ☐Sexuality ☐Legal Issues
☐Other: _____

How do you cope with stress?

_____

_____

_____

Employment Status:

☐Working Full-Time ☐Working Part-Time ☐New Job ☐Recent Job Termination ☐ Leave of absence ☐ Disability

Occupation:_____Marital Status: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Single

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Review of Symptoms

Please place a check next to any true statements in relation to your health.

General

- ❑ Poor sleep quality
- ❑ Good sleep quality
- ❑ Varying sleep quality
- ❑ Taking sleeping aids
- ❑ Sleeping <6 hours/night
- ❑ Sleeping >10 hours/night
- ❑ Frequent nighttime awakenings
- ❑ Good appetite
- ❑ Fair appetite
- ❑ Poor appetite
- ❑ Intaking artificial sweetener
- ❑ Not intaking caffeine
- ❑ Caffeine intake 100 mg/d or less
- ❑ Caffeine intake 200 mg/d or less
- ❑ Caffeine intake more than 300 mg/day
- ❑ Taking vitamins
- ❑ Taking minerals
- ❑ Taking herbal supplements

Allergy & Immune System

- ❑ Persistent infections❑
- ❑ Hives or rash
- ❑ Seasonal allergies

Cardiovascular

- ❑ Cold hands
- ❑ Cold feet
- ❑ Discoloration of hands
- ❑ Discoloration of feet
- ❑ Difficulty breathing at night
- ❑ Chest pain or discomfort
- ❑ Racing heart beats
- ❑ Skipping heart beats
- ❑ Fatigue
- ❑ Lightheadedness
- ❑ Episodes of near fainting
- ❑ Blacks-out, fainting
- ❑ Shortness of breath with exertion
- ❑ Palpitations
- ❑ Swelling of hands or feet
- ❑ Difficulty breathing while lying down
- ❑ Leg cramps with exertion
- ❑ Bluish discoloration of lips or nails

Ears, Nose, Throat

- ❑ Decreased hearing
- ❑ Ringing in the ears
- ❑ Earache
- ❑ Sensitivity to sound
- ❑ Nosebleeds
- ❑ Runny nose
- ❑ Stuffy nose
- ❑ Difficulty swallowing
- ❑ Hoarseness
- ❑ Change in voice
- ❑ Sensitivity to smells

Eyes

- ❑ Vision loss - one eye
- ❑ Vision loss - both eyes
- ❑ Double vision
- ❑ Blurred vision
- ❑ Eye pain
- ❑ Pain with eye movement
- ❑ Eye redness
- ❑ Eyes tear excessively
- ❑ Halos❑ ❑
- ❑ Light sensitivity
- ❑ Worsening of vision

Gastrointestinal

- ❑ Stomach pain
- ❑ Excessive appetite
- ❑ Loss of appetite
- ❑ Indigestion
- ❑ Heartburn
- ❑ Regurgitation
- ❑ Vomiting
- ❑ Nausea
- ❑ Painful bowel movements
- ❑ Frequent gas
- ❑ Frequent constipation
- ❑ Frequent diarrhea
- ❑ Hemorrhoids
- ❑ Change in bowel habits stream

Hematology

- ❑ Enlarged lymph nodes
- ❑ Bleeding
- ❑ Skin discoloration
- ❑ Abnormal bruising
- ❑ Fevers

Genitourinary

- ❑ Burning with urination
- ❑ Urinary frequency
- ❑ Urinary hesitancy
- ❑ Nocturia
- ❑ Incontinence
- ❑ Inability to empty the bladder
- ❑ Trouble starting urinary

Respiratory

- ❑ Sleep disturbances due to breathing
- ❑ Coughs frequently
- ❑ Shortness of breath
- ❑ Chest discomfort
- ❑ Wheezing
- ❑ Excessive sputum
- ❑ Excessive snoring
- ❑ Stops breathing during sleep
- ❑ Difficulty breathing

Neurological

- ❑ Difficulty with concentration
- ❑ Poor balance
- ❑ Numbness
- ❑ Inability to speak
- ❑ Falling down
- ❑ Tingling
- ❑ Brief paralysis
- ❑ Visual disturbances
- ❑ Seizures
- ❑ Weakness

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Review of Symptoms Cont.

Muscle/Skeletal System

- ☐ Bone pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Tender spots in muscles
- ☐ Back pain
- ☐ Muscle stiffness
- ☐ Muscle weakness
- ☐ Arthritis
- ☐ Gout
- ☐ Loss of strength
- ☐ Muscle aches

Psychological

- ☐ Sense of great danger
- ☐ Anxiety
- ☐ Thoughts of suicide
- ☐ Mental problems
- ☐ Depression
- ☐ Thoughts of violence
- ☐ Frightening visions or sounds
- ☐ Nightmares
- ☐ Night terrors
- ☐ Sleep walking

Endocrinology

- ☐ Excessive hunger
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Weight change
- ☐ Hair loss
- ☐ Lack of sexual drive
- ☐ Difficulty climaxing
- ☐ Regular menses
- ☐ Irregular menses
- ☐ Still menstruating
- ☐ Decreased length of menstrual flow
- ☐ Increased length of menstrual flow
- ☐ Excessively heavy periods
- ☐ Missed periods
- ☐ Pelvic pain
- ☐ Pain with intercourse
- ☐ Inability to conceive
- ☐ Multiple miscarriages
- ☐ Pain when ovulating
- ☐ Trying to conceive
- ☐ Currently pregnant
- ☐ Currently breast feeding
- ☐ Last Menstrual Period:

Contact Details:

On occasions, our physicians and clinical staff may need to contact you regarding your medical care. Please check below which areas you feel comfortable with us leaving your clinical information. We will use the phone numbers that you provide on the Patient Registration Form.

☐ Diamond Headache Clinic & Purath Headache & Neurology may leave a voicemail on my home voicemail system.
☐ Diamond Headache Clinic & Purath Headache & Neurology may leave a message with a family member at my home.
☐ Diamond Headache Clinic & Purath Headache & Neurology may leave a voicemail message on my cell phone voicemail system.
☐ Diamond Headache Clinic & Purath Headache & Neurology may leave a voicemail message on my work voicemail system.
☐ Diamond Headache Clinic & Purath Headache & Neurology may send text messages regarding my appointments and medical care.

By signing this form, you agree with all information that you have selected and written on this form. Please note that YOU ARE RESPONSIBLE FOR NOTIFYING OUR OFFICE OF ANY CHANGES to any portion of this form.

Patient Name (Print):_____ Patient Signature: _____

T: (414) 837-5656 | F: (414) 837-5688 | E: purath@diamondheadache,com
7701 W Barnard Ave, Greenfield, WI 53220
www.drtracipurath.com

Diamond Headache Clinic
Treatment – and beyond

Purath
HEADACHE & NEUROLOGY

Headache Patient Self-Assessment

When were you last seen? _____

How many headaches have you had since your last visit? _____

How many headaches do you have per month? _____

Have you noticed a change in the pattern with your headaches? _____

_____

What do you usually take when you have a headache? _____

On a scale of 1-10, what number is your headache when you decide to treat it? _____

When you treat your headache, does the first dose work or do you have to repeat it? _____

_____

_____

If you have to repeat it, how long do you wait before re-dosing? _____

What percent of time do you have to take a second dose? _____

Have you missed work/school/family functions due to headaches? _____

Are you satisfied with your headache control? _____

What questions do you have for Dr. Purath today? _____

_____

_____

_____

_____

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Patient Balance Payment Agreement

Our practice is acutely aware of the ever-escalating health care costs and we are doing everything feasible to help lower costs through increased efficiency. Recent changes in healthcare benefits have resulted in larger patient co-pays. Deductibles and co-insurance.

Our staff is happy to assist you in estimating the portion of our fees that may be your responsibility. However, we cannot guarantee that the information given to us by the insurance company constitutes guarantee of payment. Ultimately, it is the patient's responsibility to verify and understand his/her insurance coverage.

It is costly and inefficient to send patients a monthly statement. We request that you assist us and help to reduce billing costs by completing the credit card authorization below. By signing the authorization, you can be assured that your credit card information will be securely stared and charged only for those fees your insurance company does not pay. We honor all contractual obligations with insurance companies with which we participate. You will never be charged in excess of allowed amounts.

For those patients who prefer to pay their balance by check, a debit card or another credit card once we know your balance, we will mail you one statement for the full amount due. Full payment will be due in 30 days. If payment is not received in 30 days, the credit card you have on file will be charged for the full amount due. Any balance that exceeds 90 days will be turned over for collection with the addition of a $35.00 processing fee.

We accept checks: If your check is returned for any reason. you expressly authorize the clinic of Diamond Headache Clinic & Purath Headache & Neurology, to debit your account for the amount of the check plus a processing fee of $30.00. The use of a check for payment is your acknowledgement and acceptance of this policy.

Credit Card Authorization

I hereby authorize the clinic of Diamond Headache Clinic & Purath Headache & Neurology to charge my HSA/HRA, debit or credit card for any balance for which I am legally responsible for all charges, including deductibles, co-pays, co-insurance and non-covered items.

(Please sign and date this agreement, then present your credit card to the receptionist to scan)

Patient Name:_____ Date of Birth: _____

Cardholder:_____ Card Number: _____

Signature:

Expiration Date:_____ Date: _____

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www.drtracipurath.com

Procedure Consent

Date: _____

I authorize the performance on (name of patient): _____

of the following operation and/or procedure _____

to be performed by or under the direction of Traci A. Purath, M.D. together with associates or assistants of her choice who may be employed by Diamond Headache Clinic Purath Headache &Neurology.

_____ Has discussed with me and I understand the following items:

A. The nature and purpose of the proposed procedure(s)
B. The risks of the proposed procedure(s)
C. The possible or likely consequences of the proposed procedure(s)
D. All feasible or alternative treatments (including the risks, consequences, and probable effectiveness)

I consent to the performance of operation(s) and/or procedure(s) in addition to or those different from those now contemplated, arising from presently unforeseen conditions, which Traci A. Purath, M.D. other associates or assistants may consider necessary or advisable in emergency or life-threatening situations.

I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

I have read and fully understand this entire form. I have asked the physician any questions I may have had, and the physician has answered any questions I asked to my satisfaction.

Patient Name: _____ Patient DOB: _____

Signature (Patient/Guardian): _____ Date: _____

Witness Name: _____Witness Signature: _____

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