OGDEN CLINIC

THE DEPARTMENT OF NEUROLOGY AND SLEEP/WAKE MEDICINE
Dr. Piercey
4650 Harrison Blvd.
Ogden, UT 84403
Phone: (801) 475-3200
Fax: (801 475-3209

Patient Name: _____DOB: _____

Thank you for choosing The Neurology Center at The Ogden Clinic to serve your needs. To better help us serve you, please make note of the following:

1. Please arrive 10 minutes early. Arrivals past 10 minutes of their scheduled appointment time with paperwork not filled out may be asked to reschedule.
2. If you need to cancel your appointment please do so no later than 24 hours prior to your appointment time. Last minute cancellations and no shows are very costly and prevent others from receiving much needed care. **Cancellations or no shows less than 24 hours in advance will result in a $50 fee. Excessive, unexcused cancellations or no shows may result in discharge from the department of neurology.**
3. It is the responsibility of the patient to check with his/her insurance company regarding coverage of the appointment and all tests and procedures ordered from our office. You may call (801) 475-3500 to speak with our billing office.
4. You are asked to collect and bring with you all related medical records, such as neurological and diagnostic test reports and clinical notes done before first visit or between visits, if done at any facility other than an Ogden Clinic facility. If performed at Ogden Clinic, we will be able to access these notes. For radiological tests, CD copies and printed reports are preferred.
5. Please fill out enclosed paperwork in its entirety and to the best of your ability.
6. For all emergencies contact 911. An answering service is available but is asked to be used judiciously; connection and availability is not guaranteed. For immediate concerns and prescription refills you may try contacting your primary care provider if we are unavailable. We do not fill medications from providers outside of our office.
7. Please make arrangements for small children as these appointments are usually lengthy.
8. Please allow 7 days on prescription refill request. It is department policy that the patient be seen in the office for an appointment for all refills on medications and supplies.

PLEASE fill out the below information:

☐ Check here if it is ok to leave detailed messages on the contact numbers in your chart.

By signing below you acknowledge that you have read, understand, and agree to the above.

_____ _____
Patient or Patient Representative Date

Neurology

Dr. Piercey, MD

Name: _____ Referring Provider: _____
DOB: _____ Primary Care Provider: _____
Briefly describe purpose of today's visit/diagnosis:
_____

Past Medical History: *please circle all that apply*

High blood pressure	High cholesterol	Head trauma	Clotting disorder	Arthritis
Heart disease	Kidney disease	Dementia	Emphysema/COPD	Depression
Atrial fibrillation	Migraine/headaches	Kidney stones	Seizure	Anxiety
Thyroid disorder	Hepatitis	Parkinson's	Multiple sclerosis	Stroke
Diabetes	Ulcers	Asthma	Cancer/Type _____	Other _____

Previous Surgeries: *please list procedure and date*

Social History: *where appropriate, please check for use; how much, and current or past use*
Tobacco: current/past; type/quantity _____ Alcohol use: current/past; type/quantity _____
Caffeine: current/past; type/quantity _____ Rec. drugs: current/past; type/quantity _____
Married Divorced Single Widowed Significant other
What do you do for work?_____

Please list all of your medications below: Please use back of page or attach extra paper if needed.

Medication	Dose	Frequency

Please indicate if you have had any of the following testing done (please circle), for what purpose it was done, and where the procedure was done (which facility/office).

Head: CT MRI X-Ray Date: _____ Purpose: _____ Where: _____
Neck: CT MRI X-Ray Date: _____ Purpose: _____ Where: _____
Upper back: CT MRI X-Ray Date: _____ Purpose: _____ Where: _____
Lower back: CT MRI X-Ray Date: _____ Purpose: _____ Where: _____
Limb: CT MRI X-Ray Date: _____ Purpose: _____ Where: _____
Electroencephalogram (EEG) Date: _____ Purpose: _____ Where: _____
EMG/Nerve Conduction Study Date: _____ Purpose: _____ Where: _____
Spinal tap Date: _____ Purpose: _____ Where: _____
Echocardiogram of heart Date: _____ Purpose: _____ Where: _____
Electrocardiogram (EKG) of heart Date: _____ Purpose: _____ Where: _____
Carotid ultrasound Date: _____ Purpose: _____ Where: _____
Visual evoked potential (VEP) Date: _____ Purpose: _____ Where: _____
Sleep study Date: _____ Purpose: _____ Where: _____
Recent blood work: Date: _____ Purpose: _____ Where: _____

Neurology

Dr. Piercey, MD

Do you have any of the following symptoms?

Fever/chills	Y	N	Difficulty urinating	Y	N
Weight gain/loss	Y	N	Pain in limbs/Extremity pain	Y	N
Lightheadedness	Y	N	Joint stiffness	Y	N
Night sweats	Y	N	Muscle aches	Y	N
Blurred vision	Y	N	Painful joints	Y	N
Dry eyes	Y	N	Weakness	Y	N
Red eyes	Y	N	Eczema	Y	N
Congestion/Runny nose	Y	N	Rash	Y	N
Thyroid disease/abnormality	Y	N	Insomnia	Y	N
Shortness of breath	Y	N	New, persistent, or unusual headache	Y	N
Wheezing	Y	N	Memory loss/Dementia	Y	N
Swelling/Edema	Y	N	Seizures	Y	N
Dizziness	Y	N	Tingling/Numbness	Y	N
Palpitations	Y	N	Tremor, tic, or other movement disorder	Y	N
Ulcers	Y	N	Anxiety	Y	N
Constipation	Y	N	Depressed mood	Y	N
Diarrhea	Y	N	Difficulty sleeping	Y	N
Easy bruising	Y	N	Other _____	Y	N
Prolonged bleeding	Y	N	Other _____	Y	N
Blood in urine	Y	N	Other _____	Y	N

Family history: *Please provide information about blood relatives.*

	Dad	Mom	Brother	Sister	Son	Daughter	Dad's Dad	Dad's Mom	Mom's Dad	Mom's Mom	Other _____
Stroke											
Heart Attack											
Heart Disease											
Diabetes											
Brain Aneurysm											
Multiple Sclerosis											
Seizures											
Blood Clotting disorder											
Migraines/Headaches											
Peripheral Neuropathy											
Dementia/Alzheimer's											
Colon Cancer											
Breast Cancer											
Prostate Cancer											

Are these family members Alive (A) or Deceased (D)

Alive (A) or Deceased (D)											

Medication allergies:

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