DESERT RIDGE
NEUROLOGY

Desert Ridge Neurology
Trenton Overall, DO
Kelsie Montgomery, NP-C • Owen Ginocchio: PA-C
295 S 1470 E, STE 301, St George UT 84790
Phone: 435-775-2015 Fax: 435-775-2016
www.desertridgeneurology.com

Patient Information

Last Name:_____ First Name:_____ M.I._____

Birth date: _____ Sex: ❑ M ❑ F ❑ Other Primary Care Physician_____

Social Security #_____

What is the main reason(s) for your visit today? _____

Allergies			
❑ NONE/No Known Allergies	❑ Latex	❑ Rubber (bandaids, tape, spandex, balloons)	❑ Sulfa Drugs
Other:			

Medication Allergies – list all medications that you have allergies to, and your reaction to them:

Medication	Reaction When Taken

Medications

Preferred Pharmacy Name:	**Preferred Pharmacy Location:**

Current Medications – Please list ALL medications you are currently taking:

Name of Medication	Dosage	Frequency

History

Personal Medical Problems:(Cancer, Diabetes, Hypertension, Stroke, etc..)

Previous Surgeries:

Family Medical Problems:(Father, Mother, Siblings, Grandparents)

Tobacco Use	**Alcohol Use**	**Recreational Drug Use**
❑ Never ❑ Current – Number of Years _____	❑ Never ❑ Current – Number of Years _____ ❑ Past – Year quit _____	❑ Never ❑ Current

Authorization to release health information to: (EXAMPLE: SPOUSE/PARTNER, PARENT, CHILD)	
Name(s)	**PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** **❑ NEVER DATE:**
Release the following information: **❑ All Records** **❑ Chart Notes** **❑ Radiology Reports** **❑ Lab Reports** **❑ Other**	
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**
PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE	**DATE OF BIRTH**
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**

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REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I hereby authorize you to release medical records from:

Facility Name/Provider: _____

Phone Number: _____ Fax Number: _____

Dates of service requested: _____

Information to be released: (Please check all that apply including specific date range) This authorization will expire _____ or upon 1 year from date of execution and the undersigned may revoke this authorization in writing.

_____ Entire Medical Record

_____ Chart Notes

_____ Radiology Report(s)

_____ Lab &/or Pathology Report(s)

_____ Other

Please email records to: **info@desertridgeneurology.com**

Or mail records to: **295 S 1470 E, STE 301**
St George UT 84790
P: 435-775-2015 F :435-775-2016

Patient Signature: _____ Date: _____