Patient Information
Neurology Clinic

Patients Legal Name______________________________

Address______________________________

City______________________State__________Zip__________

Home Phone ______________Cell ______________Work______________EXT___

Date of Birth______________Age________Sex________Marital Status________

SS#______________Occupation ______________Phone________

Email Address______________________________

Emergency Contact: Name ______________Phone ______________

Spouses Name______________________Date of Birth__________

Injured on the Job__________Auto Injury ______________Date of Injury__________

IF PROPER INSURANCE INFORMATION IS NOT PROVIDED ON THE DATE OF SERVICE, OUR OFFICE IS NOT RESPONSIBLE FOR FILING BACK CHARGES. IF YOUR ACCOUNT IS TURNED OVER TO OUR COLLECTION AGENCY AN ADDITIONAL FEE, OF 25%, OF YOUR TOTAL BILL WILL BE ADDED TO YOUR BALANCE.

Primary Insurance______________________**ID#**______________

Policy holder name______________**Date of Birth**________**Relationship**________

Secondary Insurance ______________________**ID#**______________

Policyholder name ______________**Date of Birth**________**Relationship**________

I hereby assign all medical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to Neurology Clinic, P.A. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize release to my insurance carrier, employer and referring physician any information needed including diagnosis and records of any treatment or examination rendered to me to process this claim. I authorize Neurology Clinic to obtain records from hospitals and pharmacies that will assist my physician with my care. Lifetime signature authorization: This authorization and assignment are to be continuing, remaining in force until revoked in writing by the undersigned.

Patient/Legal RepresentativeSignature______________________________

Witness______________________Date______________

If patient is a minor provide parents name or legal representative and relationship.

Name______________________________

(Circle one)

Parent Grandparent Guardian Other ______________

David J. Packey, Ph.D., M.D. **Jill W. Miller M.D., Ph.D.**

Name____Date______________

Primary Care Doctor: ____________________ Referring Doctor____________________

Pharmacy name and location____

Tell us why you are here today: ____

Medical History: list all, (if none please indicate)

1.____

2.____

3.____

Surgeries/ Hospitalization: (if none please indicate)

1.____

2.____

3.____

Medications and dosages: including vitamins and aspirin, (if none please indicate)

1.______________________________5.______________________________

2.______________________________6.______________________________

3.______________________________7.______________________________

4.______________________________8.______________________________

Allergies: (to medication or drugs) and what type of reaction you have :(if none please indicate)

1.____

2.____

Family Medical History: list any illness or disease past or present

Father: ____

Mother: ____

Sibilings: ____

Ages of your children: ______________________Women # of Pregnancies______

Age: ____ Last grade of school completed _______ Are you right ___ or left ___handed?
Marital status_____________ Employed ____Retired____ Disablitity______Unemployed_____
Do you drink alcohol? _______
How many drinks daily? Beer____ Wine_____ Alcohol________ Caffeine_____
Do you currently smoke? ____ Packs per day _______
Have you smoked in the past? _____ When did you quit? ______

____________________OFFICE USE ONLY BELOW LINE____________________

BP _______WT_______HT_______PULSE_______HR_______REVIEWED BY______

General:

- Y N fevers
- Y N chills
- Y N sweats
- Y N anorexia
- Y N fatigue
- Y N sleepiness
- Y N sleep Problems
- Y N weight gain/loss

Eyes:

- Y N eye pain
- Y N vision loss
- Y N excessive tears
- Y N itching
- Y N blurring
- Y N double vision
- Y N discharge
- Y N sensitive to light

Ear,Nose,Throat:

- Y N Earache
- Y N ear discharge
- Y N ringing/ buzzing in ears
- Y N decreased hearing
- Y N congestion
- Y N nosebleeds
- Y N sore throat
- Y N hoarseness
- Y N difficulty swallowing

Cardiovascular:

- Y N chest pains
- Y N palpitations
- Y N syncope
- Y N short of breath
- Y N pacemaker
- Y N irregular heart beat
- Y N high blood pressure
- Y N murmur
- Y N angina
- Y N congestive heart failure
- Y N heart attack

Respiratory:

- Y N wheezing
- Y N short of breath
- Y N excessive sputum
- Y N cough
- Y N asthma
- Y N sleep apnea
- Y N CPAP
- Y N emphysema
- Y N bronchitis

Gastrointestinal:

- Y N constipation
- Y N diarrhea
- Y N vomiting
- Y N nausea
- Y N abdominal pain
- Y N change in bowel habits
- Y N blood in stool
- Y N jaundice
- Y N ulcer
- Y N gerd
- Y N heartburn
- Y N reflux
- Y N irritable bowel syndrome
- Y N bloating
- Y N hemorrhoids

Genitourinary:

- Y N incontinence
- Y N blood in urine
- Y N pelvic pain
- Y N genital sores
- Y N vaginal discharge
- Y N abnormal vaginal bleeding
- Y N abnormal menses
- Y N urinary tract infection
- Y N urgency
- Y N urinary hesitance
- Y N kidney stones
- Y N get up at night to urinate

Musculoskeletal:

- Y N back pain
- Y N joint pain
- Y N joint swelling
- Y N muscle cramps
- Y N muscle weakness
- Y N stiffness
- Y N neck pain
- Y N fibromyalgia
- Y N sciatica

Skin:

- Y N Rash
- Y N itching
- Y N shingles
- Y N dryness
- Y N suspicious lesions
- Y N acne
- Y N eczema
- Y N psoriasis
- Y N dermatitis
- Y N skin cancer

Neurologic:

- Y N headaches
- Y N fainting spells
- Y N seizures
- Y N weakness
- Y N dizziness
- Y N tremors
- Y N memory problems
- Y N balance problems
- Y N falls
- Y N speech difficulty
- Y N tics
- Y N drooling
- Y N pain in limb
- Y N facial pain
- Y N history of head trauma
- Y N sudden loss of vision
- Y N uncontrolled jerking
- Y N change in handwriting
- Y N history of stroke

Psychiatric:

- Y N depression
- Y N anxiety
- Y N hallucinations
- Y N paranoia

Endocrine:

- Y N cold/heat intolerance
- Y N diabetes
- Y N low testosterone
- Y N thyroid problems

Lymphatic:

- Y N anemia
- Y N abnormal bruising bleeding
- Y N enlarged lymph nodes

Have you had in the last year:

- Y N colonoscopy
- Y N mammogram
- Y N pap smear

Any Major Medical Conditions: (example cancer, heart attack or stroke.) please list on front page

Reviewed with patient

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CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I understand that I have the right to request restriction (alternate communications) as to the method of communications to me. I further understand that Neurology Clinic must honor this request of the method of communication if reasonable. Neurology Clinic may not ask me why I want the alternate method of communication.

I give Neurology Clinic permission to contact me regarding:

Appointment information, Billing Information, and Medical Information

At home? ___Yes ___No Phone #__________________

Cell phone? _____Yes _____No Cell # __________________

At work? _____Yes _____No Work # __________________

If Yes, can we leave the following information on your machine or voice mail, or should we speak to you personally?

I give my permission to speak to the following person(s) named below.

Name:____________________________Phone:__________________

Relationsship:____

Name:____________________________Phone:__________________

Relationship:____

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information for the facility directories and to family members.

I object to uses and disclosures as follows:____________________________

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I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Neurology Clinic has already taken action in reliance on my earlier effective consent.

____________________________________ ______________________

Signature of Patient or Legal Representative Signature of Witness

Date:__________________