Neurology Clinic, P.A.

PATIENT INFORMATION

Legal Name: (first)_____ (last) _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Extension _____

Date of Birth _____ Gender _____ Marital Status _____

Last four digits of SS# _____ Occupation _____

Emergency Contact Name _____

Phone _____ Relationship _____

Spouse Name _____ Date of Birth _____

Check and date if appropriate: 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 our account is turned over to our collection agency an additional fee, 25% of your total bill, will be added to your balance.

Primary Insurance _____ ID# _____

Policyholder Name _____ Date of Birth _____ Relationship _____

Secondary Insurance _____ ID# _____

Policyholder Name _____ Date of Birth _____ Relationship _____

I hereby assign all medical benefits (money paid on my behalf for my medical care) to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private medical 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 they are paid by my insurance. I authorize release to my insurance carrier, employer and / or referring health care provider any information needed, including diagnosis and records of any treatment or examination rendered to me to process the claim.

I authorize Neurology Clinic to obtain records from hospitals, health care providers, and pharmacies that will assist the health care providers at Neurology Clinic with my care.

Lifetime signature authorization: This authorization and assignment are to be continuing, remaining in force until revoked in writing by myself or legal representative.

Patient / Legal Representative _____

Witness _____ Date _____

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

Name _____ (circle) 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: _____

Medications with dosages, including vitamins and aspirin: list all (if none, please write NONE)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergies to medications, including type of reaction you have: list all (if none, please write NONE)

1. _____
2. _____
3. _____
4. _____

Surgeries / Hospitalizations: list all (if none, please write NONE)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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

Father: _____

Mother: _____

Siblings: _____

Ages of your children: _____ [for WOMEN] # of pregnancies: _____

Other Information:

Age: _____ Last grade of school completed: _____ Are you RIGHT _____ or LEFT _____ handed?

Marital Status: _____ Employed _____ Retired _____ Disability _____ Unemployed _____

Do you drink alcoholic beverages? Yes ___ No ___ How many drinks daily? Beer ___ Wine ___ Alcohol ___

Do you drink caffeinated beverage? Yes ___ No ___ How many drinks daily? ___

Do you currently use any type of tobacco? Yes ___ No ___

If yes, what type of tobacco? _____ how much? _____ how often? _____

Have you used tobacco in the past? Yes ___ No ___ If yes, when did you quit? _____

Do you have: Living will? Yes ___ No ___

Legal health care proxy / surrogate? Yes ___ No ___

If yes, does your primary care doctor have a copy of these documents? Yes ___ No ___

_____**OFFICE USE ONLY BELOW THIS LINE**_____

BP _____ WT _____ HT_____ PULSE _____ HR _____ Reviewed By _____

Patient Name _____ **DOB** _____ **Date** _____

Are you currently having or have experienced within the last month?

General:			**Cardiovascular:**			**Skin:**		
fevers	yes	no	chest pain	yes	no	rash	yes	no
chills	yes	no	palpitation	yes	no	itching	yes	no
sweats	yes	no	syncope	yes	no	dryness	yes	no
loss of appetite	yes	no	irregular heart beat	yes	no	**Neurological:**		
fatigue	yes	no	**Respiratory:**			headaches	yes	no
sleepiness	yes	no	wheezing	yes	no	fainting spells	yes	no
weight gain loss	yes	no	excessive sputum	yes	no	weakness	yes	no
Eyes:			cough	yes	no	diziness	yes	no
eye pain	yes	no	sleep apnea	yes	no	tremors	yes	no
vision loss	yes	no	**Gastrointestinal:**			memory problems	yes	no
excessive tears	yes	no	constipation	yes	no	balance problems	yes	no
itching	yes	no	diarrhea	yes	no	falls	yes	no
blurring	yes	no	vomitting	yes	no	speech difficulty	yes	no
double vision	yes	no	nausea	yes	no	tics	yes	no
discharge	yes	no	abdominal pain	yes	no	drooling	yes	no
sensitive to light	yes	no	change bowel habits	yes	no	pain in limb	yes	no
Ear, Nose, Throat:			jaundice	yes	no	facial pain	yes	no
earache	yes	no	heartburn	yes	no	sudden loss of vision	yes	no
ear discharge	yes	no	reflux	yes	no	uncontrolled jerking	yes	no
ringing/buzzing in ears	yes	no	bloating	yes	no	change in handwriting	yes	no
decreased hearing	yes	no	hemorrhoids	yes	no	**Psychiatric:**		
congestion	yes	no	**Musculoskeletal:**			depression	yes	no
nose bleeds	yes	no	back pain	yes	no	anxiety	yes	no
sore throat	yes	no	neck pain	yes	no	hallucinations	yes	no
hoarseness	yes	no	leg pain	yes	no	paranoia	yes	no
difficulty swallowing	yes	no	joint pain / swelling	yes	no	**Lymphatic:**		
			muscle cramps	yes	no	abnormal bruising	yes	no
			muscle weakness	yes	no	abnormal bleeding	yes	no
			stiffness	yes	no	enlarged lymph nodes	yes	no

PAST MEDICAL HISTORY: Please CIRCLE all medical conditions that were diagnosed by a health care provider

CARDIOVASCULAR: high blood pressure, high cholesterol, heart attack, heart murmur, pacemaker, atrial fibrillation congestive heart failure, heart valve problem/replacement, angina, peripheral vascular disease

RESPIRATORY: asthma, chronic bronchitis, emphasema, COPD, sleep apnea

GASTROINTESTINAL: ulcer, GERD, irritable bowel syndrome, gastric bypass/band/sleeve, liver problems / hepatitis

ENDOCRINE: diabetes, pituitary problems, hypothyroidism

MUSCULOSKELETAL: spinal stenosis, disc disease

NEUROLOGICAL: stroke, TIA, history of head trauma, seizures/epilepsy, Parkinson's disease, dementia, essential tremor, neuropathy, carpal tunnel syndrome

CANCER DIAGNOSIS? If YES - lung, breast, prostate, colon, brain, lymphoma/leukemia, OTHER _____

Neurology Clinic, P.A.

1333 Pine Street - Melbourne, FL 32901

Name _____ Date_____

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I understand that Neurology Clinic has a health information privacy policy. I can request the Neurology Clinic pamphlet 'Notice of Privacy Practices' should I want a copy.

I understand that I have the right to determine my preferred method of communication, and the right to restrict certain types of communication. I further understand that Neurology Clinic must honor this request as to the method of communication if reasonable. Neurology Clinic may not ask me why I want certain methods of communication.

I give Neurology Clinic permission to contact me as follows: (Check all that apply)

For APPOINTMENT information	Home phone ____	Cell phone ____	At work ____
For BILLING information	Home phone ____	Cell phone ____	At work ____
For MEDICAL information	Home phone ____	Cell phone ____	At work ____

Can messages be left on your machine or voice mail for the above numbers? Yes____ No____

Please fill in as appropriate for what you checked above:

Home phone:_____
Cell phone: _____
Work phone: _____

I give Neurology Clinic permission to speak to the person(s) named below:

Name _____ Phone _____ Relationship _____
Name _____ Phone _____ Relationship _____

I understand that I have the right to object to the use and/or disclosure of my individually identifiable personal health information to other physicians or family members.
I object to the use and/or disclosure of my health information as follows: _____
_____

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: _____

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PATIENT PORTAL

Using a computer or tablet, patients can contact Neurology Clinic to obtain an appointment, send notes to the office staff, and have access to their medical records and test results.

This is all done via a patient portal, which is available for use by a patient only AFTER that patient provides their Email address. Once a patient gives their Email address to the office staff at Neurology Clinic, they will be given information on how to sign-up for the patient portal.

Name _____ Date_____

Email Address _____

Please be assured that Neurology Clinic will not sell or share patient Email addresses, and that the Email addresses will only be used by Neurology Clinic staff members to facilitate communication with patients.