Patient Information

Date:

Name:

Address:

Home Phone: **Cell Phone:** **SSN:**

Sex: **Age:** **Birthdate:** **Marital Status:**

Race: **Ethnicity:** **Preferred Language:** **Email:**

Patient Employer/School: **Occupation:**

Employer/School Address: **Employer/School Phone:**

Whom may we thank for referring you?

In case of emergency, who should be notified? **Phone:**

Primary Insurance:

Person Responsible for Account: **Relationship to Patient:**

Address (if different from patient's):

Birthdate: **SSN:** **Phone:**

Insurance Company: **ID Number:** **Group Number:**

Secondary Insurance:

Person Responsible for Account: **Relationship to Patient:**

Address (if different from patient's):

Birthdate: **SSN:** **Phone:**

Insurance Company: **ID Number:** **Group Number:**

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with (name of insurance company) and assign directly to Neurology Outreach Clinics, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or teh benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Sign

Signature of Patient, Parent, Guardian, or Personal Representative Date

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Health History

Patient Name: _____ **Today's Date:** _____

Birth date: _

What is your reason for visit?

Symptoms Check (✓) symptoms you currently have or have had in the past year

General	Gastrointestinal	Eye, Ear, Nose, Throat	Cardiovascular	Genito-Urinary
☐Chills	☐Appetite Poor	☐Bleeding Gums	☐Chest Pain	☐Blood in Urine
☐Depression	☐Bloating	☐Blurred Vision	☐High Blood Pressure	☐Frequent Urination
☐Dizziness	☐Bowel Changes	☐Crossed Eyes	☐Irregular Heart Beat	☐Lack of Bladder Control
☐Fainting	☐Constipation	☐Difficulty Swallowing	☐Low Blood Pressure	☐Painful Urination
☐Fever	☐Diarrhea	☐Double Vision	☐Poor Circulation	
☐Forgetfulness	☐Excessive Hunger	☐Earache	☐Rapid Heart Beat	**Muscle/Joint/Bone**
☐Headache	☐Excessive Thirst	☐Ear Discharge	☐Swelling of Ankles	Pain, Weakness, Numbness in:
☐Loss of Sleep	☐Gas	☐Hay Fever	☐Varicose Veins	☐Arms
☐Loss of Weight	☐Hemorrhoids	☐Hoarseness		☐Back
☐Nervousness	☐Indigestion	☐Loss of Hearing	**Skin**	☐Feet
☐Numbness	☐Nausea	☐Nosebleeds	☐Bruise Easily	☐Hands
☐Sweats	☐Rectal Bleeding	☐Persistent Cough	☐Hives	☐Legs
	☐Stomach Pain	☐Ringing in Ears	☐Itching	☐Neck
	☐Vomiting	☐Sinus Problems	☐Change in Moles	☐Shoulders
	☐Vomiting Blood	☐Vision-Flashes	☐Rash	☐Hips
		☐Vision-Halos	☐Scars	
			☐Sore That Won't Heal	

Men ONLY	Women ONLY	Women ONLY
☐Breast Lump	☐Abnormal Pap Smear	Date of last menstrual period:
☐Erection Difficulties	☐Bleeding Between Periods	
☐Lump in Testicles	☐Breast Lump	Date of last pap smear:
☐Penis Discharge	☐Extreme Menstrual Pain	
☐Sore on Penis	☐Hot Flashes	Have you had a mammogram? ☐Yes ☐No
☐Other	☐Nipple Discharge	
	☐Painful Intercourse	Are you pregnant? ☐Yes ☐No
	☐Vaginal Discharge	
	☐Other	Number of children:

Conditions Check (✓) conditions you currently have or have had in the past year

☐AIDS	☐Chemical Dependency	☐High Cholesterol	☐Polio		**Allergies**
☐Alcoholism	☐Chicken Pox	☐HIV Positive	☐Prostate Problem		
☐Anemia	☐Diabetes	☐Kidney Disease	☐Psychiatric Care		
☐Anorexia	☐Emphysema	☐Liver Disease	☐Rheumatic Fever		
☐Appendicitis	☐Epilepsy	☐Measles	☐Scarlet Fever		
☐Arthritis	☐Glaucoma	☐Migraine	☐Stroke		
☐Asthma	☐Goiter	☐Headaches	☐Suicide Attempt		
☐Bleeding Disorders	☐Gonorrhea	☐Miscarriage	☐Thyroid Problems		
☐Breast Lump	☐Gout	☐Mononucleosis	☐Tonsillitis		
☐Bronchitis	☐Heart Disease	☐Multiple Sclerosis	☐Tuberculosis		
☐Bulimia	☐Hepatitis	☐Mumps	☐Typhoid Fever		
☐Cancer	☐Hernia	☐Pacemaker	☐Ulcer		
☐Cataracts	☐Herpes	☐Pneumonia	☐Vaginal Infections		
			☐Venereal Disease		

Patient Name: _ ___ ___ **Today's Date:** _____
Birth date: _

Family History Fill in Health Information about your immediate family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following & list relation	
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease, Strokes	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

Hospitalizations				***Pregnancies***		
Year	Hospital	Reason for Hospitalization & Outcome		Year of Birth	Sex of Child	Complications, if any

Health Habits Check (✓) which you use and how much	***Occupational*** Check (✓) if your work exposes you to:
☐ Caffeine	☐ Stress
☐ Street Drugs	☐ Heavy Lifting
☐ Other	☐ Hazardous Substances
Smoking Status: ☐ Never Smoked ☐ Current Everyday Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Current Status Unknown ☐ Unknown if Ever Smoked	☐ Other
	Occupation:

Serious Illness/Injuries	***Date***	***Outcome***

Have you ever had a blood transfusion? ☐ No ☐ Yes If Yes, Please give approx. dates

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Sign

Signature of Patient, Parent, Guardian or Personal Representative _ _ ___ _ Date

Please Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Patient Name:
Patient DOB: _

I wish to be contacted in the following manner (check all that apply)
☐ Home Telephone ☐ O.K. to leave message with detailed information ☐ Leave message with call back number only
☐ Work Telephone ☐ O.K. to leave message with detailed information ☐ Leave message with call back number only
☐ Written Communication ☐ O.K. to mail to my home address ☐ O.K. to mail to my work/office address ☐ O.K. to fax to this number
☐ Other

Sign

Patient Signature

_____

Date

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name:
Patient DOB: _

Sign

Patient Signature

_____

Date