BATAVIA NEUROLOGICAL SERVICES

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Name _____ Male / Female Race_____

Date of Birth_____Social Security #_____

Address_____City_____Zip_____

Home Phone #_____Cell #_____Work #_____

E-Mail Address_____

Employer_____ Are you working ? Yes_____No_____

__Single __Married __Divorced __Widowed Children ___Sons ___Daughters

Spouse's Name_____

Spouse's Employer _____

Primary Care Physician_____Referring Physician_____
Address_____ Address_____
Phone#_____ __ Phone#_____

Pharmacy _____Phone #_____

Mail Order Pharmacy_____

HIPPA PRIVACY How may we contact you regarding appointment and medical information. CHECK ALL THAT APPLY

Appointment Information:		Medical Information:	
Home Phone	____	Home Phone	___
Cell Phone	____	Cell Phone	___
Mobile Text	____	Mobile Text	___
Work Phone	____	Work Phone	___
Leave Message With Another Person	____	Leave Message With Another Person	___
By Mail	____	By Mail	___
By E-Mail	____	By E-Mail	___

Who we may speak with in regards to your medical care: (exclude doctors)Please include Name, relationship and phone #_____

In case of an emergency, who should we contact: Name, relationship, phone#
_____

NAME:_____DOB:_____

INSURANCE INFORMATION

Name of Health Insurance Company_____

Cardholder's Name_____Policy/ID #:_____

Cardholder's DOB_____Cardholder's SS#_____

Name of secondary Insurance Company_____

Cardholder's Name_____Policy/ID#_____

Are you filing under Workers' Compensation Yes / No

Are you filing under Motor Vehicle/No Fault Yes/ No

ALL THIS INFORMATION MUST BE COMPLETE IN ORDER TO SUBMIT A CLAIM

Date of Injury_____

Name of Insurance Company_____Phone #_____

Address_____

Claim #_____Adjuster_____

Fax # _____ (Please contact the Insurance carrier)

Name:_____DOB:_____

Why are you seeing the Doctor ? _____

What body part is to be examined ? _____ Left / Right / Both

When did the condition begin ? _____

Is Current problem a result of : Car Accident __Work Injury __ Sports Related__

How did it occur_____

I was doing the following when the condition began: (check all that apply)

__Lifting __Pulling __Pushing __Twisting __Bending __Reaching

__Squatting __Hit by object __Fall

Symptoms came on: ___Suddenly __Gradually

Do you use an assistive device ? __walker __cane __wheelchair

Review of Systems: Are you currently having problems with (Check all that apply)

__Neck pain __Back pain __Extremity pain __Numbness/Tingling __Weakness

__Balance Problems __Double/Blurred vision ___Ringing in ears/Hearing loss

__Muscle twitching/cramps __Tremor __Seizures __Black outs/Fainting

__Headaches __Dizziness __Memory Loss __Fatigue __ Insomnia

__Bowel / Bladder Problems

Have you been diagnosed with: (check all that apply)

__High Blood Pressure __High Cholesterol __ Heart Disease __Stroke __Reflux/Ulcers

__Diabetes __Thyroid __Asthma __Lung disease __Epilepsy __Arthritis __Gout __Eye disease

__DVT __Blood disease __Bone/joint disease __Multiple Sclerosis __Migraines

__Cancer /type_____ __Psychological Problems

Name:_____ DOB:_____

PAST MEDICAL HISTORY: Illnesses/Surgeries

_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____

CURRENT MEDICATIONS: You may attach a list or printout from your Pharmacy

Medication_____Dose_____How Often_____

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES_____

SOCIAL HISTORY:

Are you currently a smoker ? Yes / No __packs per day ___years
Were you a previous smoker ? Yes / No __ ____

Do you drink alcohol ? Yes / No __daily __occasionally __rarely

Do you use/or have used illegal drugs ? Yes / No Substance_____

Do you have history of drug abuse ? Yes/No

Patient Signature_____Date_____
(If under 18 years of age, Parent/Guardian must sign)