Alpha Neurology PC
Patient Updated Personal Information Sheet

**********Please complete all areas and present your current insurance card (s), along with this completed form, to the receptionist when arriving at the office for your appointment.**

Name_____DOB ___/___/____ SS_____

Address_____City_____State_____

Phone #_____Work#_____Cell #_____

Insurance Co._____ID#_____

Subscriber Name_____DOB___/____/_____

Secondary Insurance_____ID#_____

Subscriber Name_____DOB___/____/_____

In an emergency, please contact_____

Relationship to patient_____ Tel #_____

Primary Physician_____Tel #_____

*Please be sure to advise your physician at Alpha Neurology of any new allergies, surgeries or illnesses since your last visit to our office.

_____ _____

Patient Signature Date

Alpha Neurology PC

Patient Name_____Date of Birth_____Date_____

Reason for Today's Visit_____

Statistics:
Height_____
Weight_____
Right handed___ **Left handed**___

Current Medications:

_____
_____
_____
_____
_____
_____
_____
_____

NEUROLOGICAL
__**Dizziness**
__**Vertigo**
__**Memory loss**
__**Disorientation**
__**Speech or language dysfunction**
__**Inability to concentrate**
__**Seizures**
__**Taste, smell or touch disturbance**
__**Headache**
__**Migraine headache**
__**Numbness or Tingling**
__**General weakness**
__**Muscle weakness**
__**Slurred Speech**
__**Blurred vision**
__**Loss of consciousness**
__**Balance problems**
__**Falls**
__**Depression**
__**Neck pain**
__**Back pain**

CONSTITUTIONAL
__ Fatigue (sluggish, tired)
__ Weight loss
__Weight gain
__ Weight stable
__Night Sweats
__All negative

MUSCULOSKELETAL
__Muscle cramping
__twitching or pain
__Joint swelling
__Joint stiffness
__Joint pain
__Noise with joint movement
__Arm or leg pain
__All negative

SKIN
__Itching
__Scars
__Moles or lesions
__Changes in color of moles or lesions
__Rashes
__All negative

PSYCHIATRIC
__Anxiety
__sleep disturbance
__Hallucinations
__All negative
__Depression

CARDIOVASCULAR
__Chest pain
__Palpations
__Heart Murmur
__Irregular pulse
__High blood pressure
__Low blood pressure
__Swelling
__Coldness/numbness in fingers or toes
__All negative

EYES
__Itching
__ Excessive tearing
__Double vision
__Light sensitivity
__All negative

RESPIRATORY
__ Difficulty breathing
__ Chronic cough
__ Asthma
__Bronchitis
__All negative

GENITOURINARY
__Painful urination
__Frequent Urination
__Night urination
__Unable to control urination
__All negative

ENDOCRINE
__Diabetes
__Adrenal problems
__Changes in height or weight
__Increased appetite
__Increased thirst
__Hair change/loss
__All negative

HEMATOLOGIC/LYMPHATIC
__Anemia
__Bleeding tendencies
__Easy bruising
__Fatigue
__Recurrent infections
__Slow healing from cuts
__All negative

ALLERGIC/IMMUNOLOGIC
__Hay fever
__Itching
__Sneezing
__Chronic clear nasal drainage
__Conjunctivitis
__Allergies to Medication
__All negative

ENMT
__Sensitivity to noise
__Ear Pain
__Ringing in the ear
__Nosebleeds
__Sinusitis
__Vertigo
__Post nasal drip
__Bleeding gums
__Hoarseness
__Difficulty Swallowing
__All negative

GI
__Frequent heartburn
__Nausea
__Vomiting
__Constipation
__ Diarrhea
__Bloating
__All negative

_____ _____

Patient Signature HealthCare Provider Signature

Alpha Neurology PC

Name_____ Date_____

PAST Medical History: Have you been diagnosed with any of the following?

☐ Heart Disease	☐ Parkinson's disease	☐ Neuropathy	☐ Lupus	☐ Obesity
☐ Coronary Artery Disease	☐ Multiple Sclerosis	☐ Stroke	☐ Gout	☐ COPD/Emphysema
☐ Diabetes Mellitus	☐ Pacemaker	☐ Rheumatoid Arthritis	☐ Carpal Tunnel	☐ High Cholesterol

Other_____

_____

Previous Surgeries_____

_____

_____

Family History:	Father	Mother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Stroke	☐	☐	☐	☐	☐	☐
Seizure	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐
Migraine Headache	☐	☐	☐	☐	☐	☐
Neuropathy	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Respiratory Disease	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Psychiatric Disorder	☐	☐	☐	☐	☐	☐
Sudden, unexplained death	☐	☐	☐	☐	☐	☐

Social History:

Smoking: ☐ Yes, how many packs per day?_____ ☐ No, never ☐ Quit, when_____

Alcohol Use: ☐ Daily ☐ Socially

Recreational Drug use: ☐ Yes ☐ No

Employment: ☐ Employed ☐ Part Time ☐ Unemployed ☐ Retired

Marital Status: ☐ Single ☐ Married/Cohabitating ☐ Divorced/Separated ☐ Widowed

Have you, or a close family member or friend recently suffered any emotional stress: such as losing a job, a divorce, moving to a new location? If yes, please explain_____

_____

If a Physician referred you to our office, please list his/her name or list a Physician's name you would like us to send a report to.

Dr's Name_____

Address_____

_____ Patient Signature

_____ Reviewing Physician's Signature

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-Director-
Ludmila Feldman, M.D.

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Office Authorization

The term "health care provider" in this document refers to Alpha Neurology, PC, its agents and employees, members of the medical staff, their agents and employees and other health care practitioners who provide care to patients.

I understand that, as part of my health care, this organization originates and maintains health records describing my medical history, symptoms, examinations and test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as:

- The basis for planning my treatment and care.
- Information used to file my claim with the insurance company (diagnosis and procedure).
- Means by which a third-party payer can verify that billed services were actually provided.
- A tool for routine health care operations including quality and reviewing competency of your staff and/or healthcare providers.

I understand the Notice of Privacy will provide more complete information of uses and disclosure. **The Notice of Privacy is available on our website, AlphaNeurology.com or at the office for you to read, prior to signing this consent.** I understand that Alpha Neurology, PC reserves the right to change their notice and practices and will provide a copy of that changed form to me, prior to treatment. At that time I will be required to sign a new consent before receiving any services. I understand I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment or health care operations and that Alpha Neurology is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that Alpha Neurology has already taken action on my behalf.
Permission is hereby granted to all healthcare providers involved in my care to administer such examination, treatment, testing and procedures as are deemed necessary in the course of my care.
We will disclose your protected health information without your verbal authorization per individual circumstance only with your written authorization, which you may fill in below.

I authorize the release of my protected health information with regard to the minimum necessary policy, to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

RELEASE OF INFORMATION

Information necessary to substantiate my insurance claims may be released by the healthcare provider in my care.

FINANCIAL RESPONSIBILITY ASSIGNMENT OF BENEFITS

For those healthcare providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those healthcare providers who have rendered services to me and who accept such assignment. I agree I have to pay all charges that are not paid in full by assigned insurance. For those insurances in which Alpha Neurology participates this charge shall not exceed the allowed or contracted amount as determined by said insurance company. If such amounts due to the healthcare providers are not paid after reasonable notice, that account shall be deemed delinquent and a service fee can be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. In this case, the debt may be assigned to a third party for collection fees and interest due on amounts in default.

***There will be a cancellation fee of $25.00 if you fail to cancel at least 24 hours before your appointment.**

_____ _____
Name of Patient or Responsible Party (Please Print) Date

_____ _____
Signature of Patient or Responsible Specify Relationship, if not patient