Florida Nerve Medicine, L.L.C.
Hildgarde Geisse, M.D.
Neurology

Patient Registration Form

First Name: _____ MI: _____ Last Name:_____

Date of Birth: _____

Address: _____

City: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SSN: _____Email: _____

Home Phone:_____Cell Phone:_____

Occupation:_____Employer:_____

Emergency Contact:_____Phone:_____

Pharmacy Name: _____ Pharmacy Phone: _____

Reason for visit:_____

Is this visit due to an auto accident, or work, related injury?

Yes ☐ No ☐

Claim Number:_____Date of Accident:_____

Attorney:_____Adjuster Namer:_____

Insurance Information

Primary Insurance Company:_____

Group Number:_____Policy Number:_____

Subscriber's Name:_____ Relation:_____

Subscriber's DOB:_____

Secondary Insurance Company:

Group:_____Policy Number:_____

Subscriber's Name:_____Relation:_____

Subscriber DOB:_____

6400 N Andrews Ave Suite #530 * Fort Lauderdale, FL 33309 * 954-530-4344 * Fax 561-429-3630
Dr.Geisse@floridanervemedicine.com

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If the Patient is a minor, please complete the following:

Father's Name:_____DOB:_____

Father's Phone:_____Father's Email:_____

Father's Address:_____

Mother's Name:_____DOB:_____

Mother's Phone:_____Mother's Email:_____

Moterh's Address:_____

Social History Information:

Are you claustrophobic: Yes ☐ No ☐

Do you have a prior history of substance abuse? ☐ Yes No ☐

Please list substances:_____

Do you currently smoke? Yes ☐ No ☐

How many packs per day did you smoke?_____

How many years have you been smoking?_____

Did you smoke in the past? Yes ☐ No ☐

If yes, when did you quit?_____

How many years did you smoke?_____

Do you drink alcohol? Yes ☐ No ☐

Number of drinks: per day _____ per week_____

Do you have any children: Yes ☐ No ☐

If so, how many children do you have?_____

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Family Health History

Relative	If living: Age & Current Health Condition		If deceased: Age & Cause of death		Has any blood relative ever had this?		Which blood relative had this disease?
Mother					Cancer	Yes ☐ No ☐	
Father					Diabetes	Yes ☐ No ☐	
Brother					Heart Disease	Yes ☐ No ☐	
Sister					High Blood Pressure	Yes ☐ No ☐	
Brother					Migraine Headaches	Yes ☐ No ☐	
Sister						Yes ☐ No ☐	
Brother						Yes ☐ No ☐	
Sister						Yes ☐ No ☐	

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Patient Name:_____ **Date of Birth:**_____

Past Medical History

☐ Atrial Fibrillation ☐ Brain Surgery ☐ Brain Tumor ☐ Cancer
☐ Carotid Stenosis ☐ Chicken Pox ☐ Cold Sores ☐ Concussion
☐ Diabetes ☐ Difficulty Walking ☐ Encephalitis
☐ Genetic Disease ☐ Genital Herpes ☐ Headaches ☐ Head Injury
☐ Heart Trouble ☐ High Blood Pressure ☐ High Cholesterol
☐ Inherited Neurologic Disease ☐ Kidney Disease ☐ Liver Disease
☐ Loss of Consciousness ☐ Lyme ☐ Measles ☐ Meningitis
☐ Multiple Sclerosis ☐ Muscle Disease ☐ Neuropathy
☐ Parkinson's ☐ Polio ☐ Rheumatic Fever ☐ Seizures ☐ Shingles
☐ Sinus Infection ☐ Sleep Difficult ☐ Stroke ☐ Thyroid Disease
☐ TIA (stroke which went away) ☐ Tremors

Surgical Operations or Hospitalization:

Type:_____ Date_____

Type:_____ Date_____

Type:_____ Date_____

Type:_____ Date_____

Injuries, Car Accidents or Fractured Bones:

Type:_____ Date_____

Type:_____ Date_____

Type:_____ Date_____

Type:_____ Date_____

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Patient Name:_____ **Date of Birth:**_____

Medications & Vitamin Supplements

Please list all

prescription medications, over the counter medications, and vitamin supplements.

Drug Allergies: _____

_____

_____

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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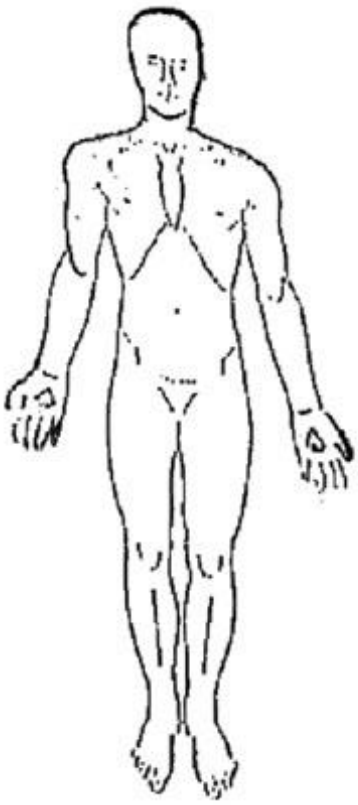
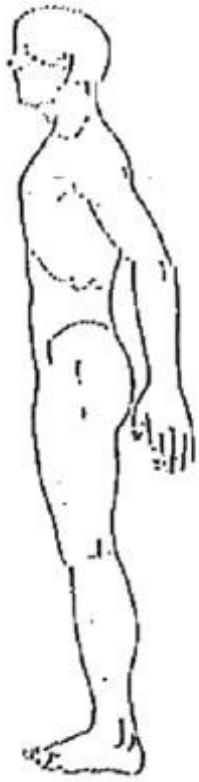
Pain Assessment

Please mark where you feel pain:

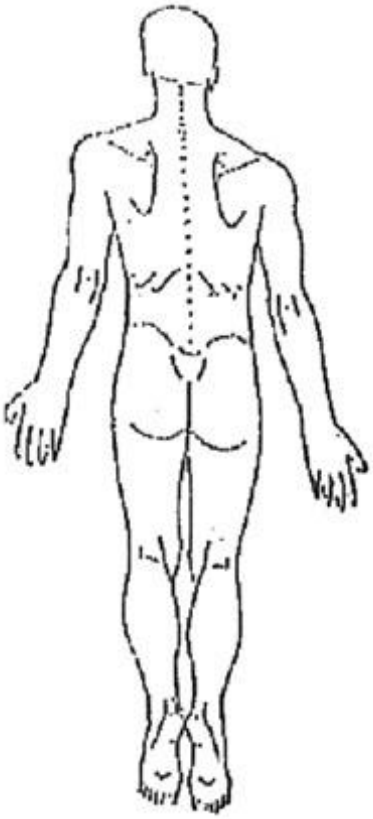
Right, Front, Left



Right Side



Left, Back, Right



Left Side

Please describe pain level from 1 – 10: _____

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Review of Systems

Please circle, and provide brief details for, the symptoms
listed below that apply to you now, or have within the last year.

Neurologic

Headache
Weakness
Stiffness
Numbness/tingling
Seizures or convulsions
Neck pain
Back pain
Difficulty walking
Falls
Tremors
Memory loss/confusion

Constitutional Symptoms

Fever
Night Sweats
Fatigue
Weight Loss
Weight Gain
Insomnia/Trouble Sleeping

Cardiovascular

Chest Pain
Irregular Heartbeat
Shortness of Breath
Palpitations
Swelling (feet, ankles, hands)

Psychological

Anxiety
Depression
Auditory Hallucinations
Visual Hallucinations
Fear/Phobia

Gastrointestinal

Loss of Appetite
Diarrhea
Constipation
Nausea
Vomiting

Ear/Nose/Throat

Hearing Loss
Ringing in ears
Dizziness
Vertigo
Nose Bleeds
Sinusitis
Lack of taste or smell

Genitourinary

Difficulty Urinating
Frequent Urinating
Blood in Urine
Painful Urination

Eyes

Blurred Vision
Double Vision
Pain behind Eyes
Eye Drooping

HIPAA

Notice of Privacy Policies

This Notice of Privacy Practices describes how we may use, and disclose, your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for purposes required by law and describes your rights to access and control your protected health information. "Protected Information" is information about you, including demographic information, that may identify you as it relates to your past, present, future physical and mental health, or condition, and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff, and anyone outside of our office who are involved in your care, and treatment, for the purpose of providing health services to you, to pay your health care bills, to support the operation of the physician's practice, and other uses required by law.

Treatment. We will use, and disclose, your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination, or management, of your care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you; OR your protected health information may be provided to a physician to whom you have been referred to in order to ensure that the physician has the necessary information to diagnose or treat you.

Payment. Your protected health information will be used, as needed, to obtain payment for your care services. For example, obtaining approval for a medical procedure may require that your protected health care information be disclosed to the health insurance plan to establish medical necessity.

Healthcare Operations. We may use or disclose, as needed, your Protected Health Information in order to conduct the normal day to day operations of our practice which include, but are not limited to: Quality Control, Licensing, Employee Reviews, and Training of Medical Students.

For example, we may disclose your Protected Health Information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked your name and indicate your physician. We may also call you by name in the waiting room when the physician is ready to see you. We may use, or disclose, your Protected Health Information in the following situations without authorization, as required by law: Public Health Concerns, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donations, Research, Criminal Activity, Military Activity, National Security, Worker's Compensation, Inmates, Required User Disclosures, Under Lay.

We must make a disclosure to you when we are required by the Secretary of the Department of Health and Human Services to investigate, or determine, our compliance with the requirement of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with the consent, authorization, or opportunity to object, unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician, or the physician's practice, has taken an action in relation to the use, or disclosure, indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your Protected Health Information. If you have any objections to this form, please ask to speak with our privacy officer.

You have the right to inspect and copy your Protected Health Information. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of our Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information for the purpose of treatment, payment, or healthcare operations.

You may also request that any part of your Protected Health Information not be disclosed to family members, or friends, who may be involved in your care for notifications purposes as described in this Notice of Privacy Practices. Your request must state the

specific restrictions, and which they apply. Your physician is not required to agree to a restriction that you may request. If your physician believes your restriction is unreasonable, and it is in your best interest to permit use and disclosure your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you have the right to use another Healthcare Professional.

You have the right to request, and receive, confidential communications from us by alternative means, or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically or by fax.

You may have the right to have our physician amend your Protected Health Information. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we subsequently submit a rebuttal to your statement we will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if an, of your Protected Health Information. We reserve the right to change the terms of this notice and will inform you by mail of any changes made. You then have the right to object, or withdraw, as provided in this notice.

Complaints

You may complain to the U.S. Department of Health and Human Services, 200 Independence Ave, S.W. Washington, D.C. 20201, if you believe your privacy rights have been violated by us you may file a complaint with us by notifying our HIPAA Privacy Officer. We will not retaliate against you for filing a complaint.

Law requires us to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to the Protected Health Information.

Signing below acknowledges you have received our Notice of Privacy Practices.

Print Name	Signature	Date

This notice was published, and becomes effective, on January 22, 2008.