Bucks Mercer Neurology

JAMES A. WARE, JR., M.D.

Today's date: / /

PATIENT INFORMATION

Patient's Name | Age | Sex

Birth Date - - | **Marital status** (circle one) Single / Mar / Div / Sep / Widow | SS# - -

Address | City | State | Zip

Home phone ( ) | Work Phone ( ) | Cell Phone ( )

Preferred telephone contact ❑ Home ❑ Cell ❑ Work

Do we have permission to leave a message ❑ Yes ❑ No

Do we have permission to contact you via email ❑ Yes ❑ No

Email:

EMPLOYER

Name | Occupation

Address | City | State | Zip

Phone ( ) | Fax ( )

EMERGENCY CONTACT

Name | Relation

Address | City | State | Zip

Phone ( ) | Work ( )

REFERRED BY (PLEASE INCLUDE COMPLETE ADDRESS IF REFERRED BY PHYSICIAN)

Name

Address | City | State | Zip

Phone ( ) | Fax ( )

MEDICAL HISTORY

Date of Injury | Family Physician

Type of Injury (Check one) ❑ Auto ❑ Workers Compensation ❑ Legal ❑ Other

Is condition a result of accident ❑ Yes ❑ No Pre-Existing Condition ❑ Yes ❑ No

PHARMACY INFORMATION

Name	Phone ( )		
Address	City	State	Zip

Continued on next page

RESPONSIBLE PARTY INFORMATION IF SAME AS PATIENT, CHECK HERE____, LEAVE THIS SECTION BLANK AND CONTINUE ON TO THE INSURANCE SECTION			
Name (Parent if Minor)		Birth date: - -	SS# - -
Address	City	State	Zip
Phone ( )		Work ( )	

INSURANCE INFORMATION – PRIMARY INSURANCE			
Insurance Carrier		Policy Holder Name	
Relationship to Patient		Birth date: - -	SS# - -
Policy Holder's Employer			
Employer's Address	City	State	Zip
Phone ( )		Work ( )	
Policy Number#	Group Number#		

INSURANCE INFORMATION – SECONDARY INSURANCE			
Insurance Carrier		Policy Holder Name	
Relationship to Patient		Birth date: - -	SS# - -
Policy Holder's Employer			
Employer's Address	City	State	Zip
Phone ( )		Work ( )	
Policy Number#	Group Number#		

Please read, sign and date the following to allow us to bill your insurance company for your medical care

Release: I hereby consent to the release of information provide to, or generated by Bucks Mercer Neurology, to my primary care physician, referring physician, physical therapist, attorney, insurance carrier(s), agency or other party with a bonafide, pertinent interest via verbal, written, or fax/email communication. A copy or scanned image of my signature shall be as valid as the original.

Assignment: I hereby assign medical benefits otherwise payable to me to Bucks Mercer Neurology. I assume financial responsibility for any copays, deductibles, co-insurances and balances. Copays are due at the time of service and other balances are due upon receipt of invoice. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to Bucks Mercer Neurology.

Consent to Treatment: I hereby consent to examination and treatment by Bucks Mercer Neurology.

Verification: I hereby verify that all the above information if true and correct as of the date signed below.

Print Name _____ **Date**_____

Signature of Patient _____

Patient/Guardian Signature

Medicare/Medicaid & Medigap Assignment of Benefits : I request that payment of authorized Medicare/Medicaid & Medigap benefits be made on my behalf to Bucks Mercer Neurology for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the centers for Medicare, Medicaid Services & Medigap any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient _____ **Date**_____

Patient/Guardian Signature

HIPAA Notice of Privacy Practices

Bucks Mercer Neurology
396 Whitehorse Avenue
Hamilton, NJ 08610

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact or office, at (609) 585-0118.

OUR OBLIGATIONS: We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

HIPAA Notice of Privacy Practices

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2)
to protect your health and safety the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information
Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the Privacy Officer, in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the cost of copying, mailing, or other associated supplies ($1.00 per page). We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.
To request an amendment, complete and submit a Medical Record Amendment Correction Form to the *Privacy Officer*. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.
In addition, we may deny your request if you ask us to amend the information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of the medical information about you for the purposed other then treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing to the *Privacy Officer*. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper of electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the *Privacy Officer*. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the *Privacy Officer*. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact: Privacy Officer: Bucks Mercer Neurology, 396 Whitehorse Avenue, Hamilton, NJ 08610.

All complaints must be made in writing. **You will not be penalized for filing a complaint**.

I, _____ hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____

Date:_____

If not signed, reason why acknowledgement was not obtained.

_____
_____
_____
_____

Staff Witness seeking acknowledgement

_____

Date:_____

Bucks Mercer Neurology
396 Whitehorse Avenue
Hamilton, NJ 08610

Office Policies

Welcome to our practice. It is an honor to care for you and your family. Please take a few minutes to review this document and sign where indicated. We are glad to answer questions regarding our office policies.

Appointments
Documentation: Our office needs certain documentation to serve you (i.e. insurance card, referral and/or out of network authorization, driver's license, and any change of your personal information). It is necessary to have this documentation with you at the time of your visit. If you are an established patient please inform the receptionist of any changes to your address, phone number, or other patient information. Not having the proper documentation may cause you to be **financially responsible** for your office visit. **It is the patient's responsibility to obtain any needed referrals.**
Timeliness: Please arrive 15 minutes prior to your scheduled appointment. We strive to keep on schedule and we do our best to notify our patients if there is a delay in our doctors' schedules. We ask for your patience and understanding in the event that there is an emergency while you are here for your appointment. If you are late for your appointment, we reserve the right to reschedule.
Cancellations, Charges for Missed Appointments: Cancellations for appointments/surgeries require a minimum of 24 hours advance notice. Failure to provide such advance notice may result in a charge of $25.00 for a missed office visit. Those who repeatedly miss appointments will need to have a credit card on file to hold an appointment.
Follow-up: Please schedule your follow-up appointment if needed before leaving the office as this will enable us to better accommodate any scheduling needs.
Minors: Children under the age of 18 must be accompanied by a parent or an adult guardian who has appropriate documentation, such as a written parental permission. Our staff is not permitted to watch your child while you are receiving care at the practice. Please make arrangements prior to arriving at the practice for your appointments.
Billing
Patient Financial Responsibility: Payments for copayments, deductibles as set forth by your insurance company are due at the time of service. Any coinsurances, deductibles, or non-covered services as determined by your benefit plan will be billed to you and are due upon receipt of bill.
Self Pay/Non Participating Providers: Self pay and patients with non participating health plans are responsible for the bill at the time of service.
Payment Methods: We accept cash, personal checks, American Express, Discover, MasterCard and Visa.
Cost of Collection: Delinquent accounts may result in additional billing costs. Balances sent to a collection agency or attorney will result in a collection surcharge of $50.00 or 35% of balance, whichever is greater. Patient is responsible for any additional fees incurred in collecting past due balances.
Returned Checks: will result in a $30.00 fee or the actual bank fee, whichever is greater.
Workers' Compensation/ No Fault Accident At the time of service it is the patient's responsibility to clearly identify those medical injuries/conditions which he/she believes are due to a motor vehicle accident or are work related.
Workers' Compensation Claims: Submission of claims to be covered by Workers' Compensation requires written authorization from your employer or their Workers' Compensation Insurance Carrier prior to your first visit. Denied charges due to lack of proper authorization will be your responsibility. Your private insurance cannot be used to cover treatment for injuries/conditions sustained at work unless Workers' Compensation coverage has been denied, does not exist, or your case has been settled.
Motor Vehicle (PIP) Claims: Insurance claims resulting from Motor Vehicle accidents must be submitted to the Motor Vehicle (PIP) carrier and cannot be billed to private insurance unless PIP coverage has been denied, does not exist, or private insurance was selected as the primary motor vehicle carrier. The patient is responsible for any deductible or co-payments under the PIP coverage. Your private health insurance may cover these items and we will need this information for claims processing.
MRI/ Other Studies

Continued on next page

Pre-certifications: Prior to scheduling an appointment for a prescribed study (i.e. MRI, CT Scan or Ultrasound) insurance precertification may be required. Your insurance company may not pay for your testing if you do not have their required precertification approval. We are finding that insurance companies are increasing their demands and requirements for processing precertification requests. As a result, it may take 3-7 business days to accomplish/finalize this task. Our office does everything that we can to expedite the process.

Study Results: It is your responsibility to contact our office once your study has been scheduled (whether it be blood work, CT Scan, MRI or other study). Please call our office so that a follow-up appointment can be scheduled with your doctor. Please provide us with the name of the facility and the date of the test. The doctor will discuss the test results and any additional treatment at the follow-up appointment.

Botox: Prior to scheduling an appointment for a Botox injection, insurance precertification may be required. Your insurance company may not pay for your testing if you do not have their required precertification approval. We are finding that insurance companies are increasing their demands and requirements for processing precertification requests. It is essential that you inform us if you are or may be pregnant or receiving chemo or radiation therapy.

EMG testing & Results: It is our office policies that these test are done in 2 session. Our office will make 3 appointments when the doctor prescribes the testing, any cancelation of these appointments will require our office to reschedule the parts of the tests or follow up appointments. The doctor will only go over the test at your follow up visit

EEG Testing: Since the electrodes are attached to your scalp, make sure your hair is clean and free of sprays, oils, creams, and lotions. Shampoo your hair and rinse with clear water the evening before or the morning of the test. Do not put any hair conditioner or oil on after shampooing. Your hair must be dry.

Copies of Medical Records/ Form Completion

Copies of Medical Records: Original medical records are the property of the provider. Copies can be reproduced for a charge of $1.00 per page or, if the record is less than 10 pages $10.00, but no more than $100.00 for the complete copy. You can request copies by completing our medical record release form. We will let you know the appropriate charge as outlined above. We will have them ready for you within 30 days of receipt of your request and payment.

Administrative Forms: We may charge up to $25.00 for completing administrative forms (ex: school, life insurance, disability, DMV). This fee is not covered by insurance and payment is required in advance. Please allow 5 business days for completion of forms.

Prescriptions

Prescription Refills: Please call for a refill before you run out of your medication. We may not refill prescriptions if you are overdue for your office visit. It may take up to 48 hours for refill approval and fulfillment. We do not refill prescriptions during evenings or weekends.
Many narcotics cannot be refilled over the phone; you may be required to come to the office in person to pick up your prescription for the medication refill. Due to legal and regulatory guidelines, we may not be able to issue replacements for narcotic medication prescriptions that have been lost, damaged or stolen.

General Information

Cell Phone Usage: Please refrain from using cell phones in our office.

Acknowledge and Agreement to the terms and conditions of this document:

_____

Patient's Name Date

X_____

Patient/Parent/Guardian Signature Printed Name

James A. Ware, Jr., MD
Bucks Mercer Neurology
396 Whitehorse Ave.
1st Floor
Hamilton, NJ 08610
Phone: 609-585-0118
Fax: 609-585-0244

ePrescribing Consent Form

ePrescribing is now being mandated by Congress for the purpose of providing error free, accurate prescriptions to a pharmacy from a physician. The *Medicare Modernization Act* of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Bucks Mercer Neurology can request and use your prescription medication history from other healthcare providers and or/third party pharmacy benefit payors for treatment purposes.

Understanding all of the above. I hereby provide informed consent to Bucks Mercer Neurology to enroll me in the ePrescribe program. **Controlled substances (ex: Narcotics) are excluded from the ePrescibe Program.**

Patient Name (Print) _____ Date of Birth _____

Signature of *Patient/Guardian Signature* _____ Date _____

Relationship to Patient _____

PHARMACY INFORMATION:

Name _____ Phone ( )

Address _____ City _____ State _____ Zip _____

Consent Denied/Revoked:

Signature _____ Date _____

BUCKS MERCER NEUROLOGY
396 WHITEHORSE AVENUE
HAMILTON, NJ08610

HEALTH HISTORY FORM

DATE: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Sex : ❑Male ❑Female Marital Status: Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow ❑

Primary Care Physician: _____ Phone#: _____ Fax #: _____

Referring Physician: _____ Phone#: _____ Fax #: _____

Reason for your visit today:

1. _____
2. _____
3. _____

How long have you had these problems? _____

How often do they occur? _____

What other doctors have you seen? _____

Personal Social History:

Occupation: _____

Tobacco: ❑ Nonsmoker ❑Former smoker. Quit Month/Year: _____ ❑Current smoker, How many/day? _____

Alcohol: ❑ Yes ❑ No If yes, how much and how often? _____

Take recreation Drugs ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No

Drug/Food Allergies: _____

_____

REVIEW OF SYSTEMS: Check (☑) if you had any of the following during the past **three months?**

CARDIC/RESPIRATORY
O Blue Lips/Nail Beds
O Chest Pain
O Cough
O Difficulty Breathing
O Shortness of Breath
O Sputum
O Varicose Veins
O **None of the Above**

INTESTINES
O Abdomen Pain
O Appetite Change
O Constipation
O Diarrhea
O Jaundice
O Nausea Vomiting
O Weight Change
O **None of the Above**

SKIN
O Fluid Retention
O Itching
O Rash
O Sores
O Temperature(Extreme Hot or Cold)
O **None of the Above**

HEAD, EARS, EYES, NOSE, THROAT
O Back Pain
O Headaches
O Hearing Loss
O Joint Pain
O Limited Motion
O Muscle Aches & Pains
O Muscle Weakness
O Nose Bleed
O Ringing Ears
O Sore Throat
O **None of the Above**

NEUROLOGICAL
O Anxiousness
O Dizziness
O Dreams/Nightmares
O Equilibrium (balance)
O Headaches
O Numbness
O Speech difficulty
O Sensory loss
O **None of the Above**

URINARY
O Blood In Urine
O Incontinence
O Little or no urine
O Pus in urine
O Stones
O Urinary Frequency
O **None of the Above**

Patient Name:_____

FAMILY MEDICAL HISTORY - HAVE YOU EVER BEEN SUSPECTED OF HAVING THE FOLLOWING PLEASE Check (☑)					
	Self	**Father**	**Mother**	**Siblings**	**Children**
				Number Of_____	Number Of _____
		Living/Deceased	Living/Deceased	Living/Deceased	Living/Deceased
Deceased (Cause Of Death)					
Alzheimer's					
Anxiety					
Back Pain Or Injury					
Bleeding Disorder					
Cancer (Specify Type Of Cancer)					
Depression					
Diabetes I/II					
Heart Attack					
High Blood Pressure					
Heart Disease					
High Cholesterol					
Hypertension					
Kidney Disease					
Liver Disease					
Lung Disease					
Mental Illness					
Migraine/Headaches					
Multiple Sclerosis					
Muscle Disorder					
Neurological Problems					
Parkinson's					
Rheumatoid Arthritis					
Seizure					
Stroke					
Thyroid Disease					
Other (Specify)					

Prior Surgical History (List date of surgery in the space provided). If you had no surgeries, please check here ○ None

	Date		Date		Date
○ Appendectomy	_____	○ Heart Bypass Surgery	_____	○ Neck Surgery	_____
○ Carotid Artery Surgery	_____	○ Heart Stents	_____	○ Thyroid Surgery	_____
○ Carpal Tunnel Surgery	_____	○ Knee Surgery	_____	○ Other	_____
○ Cranial Surgery	_____	○ Low Back Surgery	_____	○ Other	_____

COMMENTS OR ADDITIONAL INFORMATION:

_____

_____

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

Bucks Mercer Neurology
396 Whitehorse Ave.
1st Floor
Hamilton, NJ 08610
Phone: 609-585-0118
Fax: 609-585-0244

MEDICATION LIST

PATIENT NAME _____ **PHARMACY NAME** _____ **PHARMACY #** _____

MEDICATIONS	STRENGTH	FREQUENCY	REASON