Neurology East
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NEW PATIENT, UPDATE, OR HOSPITAL FOLLOW-UP NEUROLOGY QUESTIONNAIRE

Name:_____

Address:_____

City:_____ State: _____Zip Code:_____

Home Phone: _____Cell Phone:_____

SS#_____-_____-_____D.O.B. _____/_____/_____

Race:_____ Gender:_____

Email Address: _____

Emergency Contact: _____ Phone #:_____

Reason for Consultation:_____

How would you describe your main problem right now? _____

_____

Allergies:

_____

_____

List of ALL Medications (prescription and over the counter) with dosage:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE CIRCLE ANY THAT PERTAIN TO YOU

Your Past Medical History:

Diabetes
High Blood Pressure
Cancer (Type) _____
Stroke
Atrial Fibrillation
Coronary Disease
Heart Failure
AIDS/HIV
Other_____

Kidney Disease
Arthritis/Gout
Thyroid Disease
Bleeding Problem
Venereal Disease
Lung Disease
Liver Disease

List any surgeries you have had - Type of Operation: **Year**

_____ _____

_____ _____

_____ _____

_____ _____

Social History:

Marital Status: S M D W

How far did you go in school?_____

Do you smoke? _____ If yes, current packs per day: _____

Do you drink? _____ If yes, how much? _____

How many children do you have? _____

What is your occupation? _____

Place of Employment: _____

Family History - List any medical conditions of your parents:

Mother: _____

Father: _____

Mother alive? _____ Father alive? _____

List any medical conditions that run in your family:

_____

_____

_____

SYSTEM REVIEW

Constitutional Symptoms

Good general health lately	**No**	**Yes**
Recent weight change	**No**	**Yes**
Fever	**No**	**Yes**
Fatigue	**No**	**Yes**
Headache	**No**	**Yes**

Respiratory

Chronic or Frequent Cough	**No**	**Yes**
Spitting up blood	**No**	**Yes**
Shortness of breath	**No**	**Yes**
Asthma or wheezing	**No**	**Yes**
Do you snore?	**No**	**Yes**

EYES

Eye disease or injury

Wear eye glasses/contact lenses

Blurred or double vision

Glaucoma

EARS/NOSE/MOUTH/THROAT

Sore throat or voice change

Earaches or drainage

Chronic sinus problems

Nose bleeds

Mouth sores/bleeding gums

Swollen glands in neck

GENITOURINARY

Frequent urination

Burning or painful urination

Change in force of stream

Incontinence or dribbling

Blood in urine

Kidney stones

Sexual difficulty

GASTROINTESTINAL

Loss of appetite

Change in bowel movements

Nausea or vomiting

Frequent diarrhea

Peptic ulcer

Constipation

Rectal bleeding/blood in stool

Abdominal pain or heart burn

MUSCULOSKELETAL

Joint Pain

Joint stiffness or swelling

Weakness of muscles or joints

Back Pain

Cold extremities

NEUROLOGICAL

Frequent or recent headaches

Light headed or dizzy

Convulsions or seizures

Numbness or tingling

Head Injury

Tremors

Paralysis

Stroke

CARDIOVASCULAR

Chest pain or angina pectoris

Shortness of breath

Swelling (feet, ankles, hands)

Palpitations

INTEGUMENTARY

Rash or itching

Change in skin

Change in hair or nails

Varicose veins

Breast pain, lump or discharge

ENDOCRINE

Thyroid or hormone problem

Diabetes

Excessive thirst/urination

Hot or cold tolerance

Are eyes becoming drier

Change in hat or glove size

PSYCHIATRIC

Memory loss or confusion

Anxiety

Sadness

Insomnia/Trouble sleeping

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts

Bleeding or bruising tendency

Anemia

Phlebitis

Past transfusion

Enlarged glands

Insurance Company Name: _____

Name of Contract Holder and Date of Birth:_____

Signature:_____ Date: _____/_____/_____

PHARMACY INFORMATION

OUR OFFICE WILL BEGIN USING E-PRESCRIBING TO FILL PRESCRIPTIONS

E-PRESCRIBING- A PRESCRIBER'S ABILITY TO ELECTRONICALLY SEND AN ACCURATE, ERROR FREE AND UNDERSTANDABLE PRESCRIPTION DIRECTLY TO A PHARMACY FROM THE POINT-OF-CARE-IS AN IMPORTANT ELEMENT IN IMPROVING THE QUALITY OF PATIENT CARE.

PATIENT NAME:_____

DATE OF BIRTH: _____

PHARMACY NAME: _____

ADDRESS/LOCATION:_____

_____

PHONE:_____ FAX:_____

Neurology East
Patient Contact Information Sheet
Release Medical Information & Related Test Results

Patient Name: _____

Social Security Number:_____

Any physician, staff, employee or representative of Neurology East has my permission to discuss my account and medical conditions which may include Symptoms, treatments, diagnosis, test results, medications or any other type of protected health information which the following person(s) in order to facilitate and coordinate my care, treatment, and payment:

_____ONLY TO MYSELF

_____ANY MEMBER OF MY FAMILY

_____MAY LEAVE TEST RESULTS ON MY ANSWERING MACHINE

ONLY RELEASE TO THE FOLLOWING FAMILY MEMBERS:

Name_____ Relationship _____Phone#_____

Name_____Relationship_____Phone#_____

Name_____ Relationship _____Phone#_____

Name_____Relationship_____Phone#_____

I understand that authorization the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can Revoke it by writing to Neurology East or complete a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if the information is shared with the above individuals it may be subject to redisclosure by the individual (s).

ASSIGMENT OF BENEFITS FORM

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignments of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my Insurance carrier(s), including Medicare, private insurance and health/medical plan, to issue payment check(s) directly to Neurology East for medical services rendered to myself and/or my dependents regardless of my insurance benefits. If any. I understand that, I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Neurology East to: (1) release any information to insurance carriers regarding my illness and treatments. (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Neurology East on behalf of myself and/or my dependents, understand that by making the request. I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of the assignment is to be considered as valid as the original.

My signature below validates I have received a copy of my Individual Patient Rights with Regards to HIPAA.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Print Name Patient Date of Birth