

MID ATLANTIC NEUROLOGY & SLEEP MEDICINE, PA

PATIENT INFORMATION

SSN: _____

PATIENT NAME: _____ DOB: _____ SEX: M / F

ADDRESS: _____ STATE: _____ ZIP: _____

PHONE #'S: (HOME) _____ (CELL) _____ (WORK) _____

E-MAIL: _____ PREFERRED METHOD OF CONTACT: HOME / CELL / WORK

MARITAL STATUS (CIRCLE ONE): SINGLE / MARRIED / SEPARATED / DIVORCED / WIDOWED

RACE (CIRCLE): CAUCASIAN / AFRICAN AMERICAN / ASIAN / NATIVE (INDIAN) AMERICAN / HISPANIC / OTHER _____

(If patient is under the age of 18): NAME OF RESPONSIBLE PARTY _____ DOB: _____ SSN: _____

INSURANCE INFORMATION

PRIMARY: _____ SUBSCRIBER: _____

ID#: _____ GROUP#: _____

SUBSCRIBER'S DOB: _____ SSN: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY: _____ SUBSCRIBER: _____

ID#: _____ GROUP#: _____

SUBSCRIBER'S DOB: _____ SSN: _____ RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACTS: Please circle whether they are authorized to receive medical information under HIPAA. YES / NO

NAME: _____ RELATIONSHIP: _____ PHONE#: _____

NAME: _____ RELATIONSHIP: _____ PHONE#: _____

All professional services rendered are charged to the patient. The necessary forms will be completed to expedite insurance carrier payments. I give permission to Mid Atlantic Neurology to release my health information to the insurer to receive payment. The patient is responsible for all charges, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. _____ Initial

In the event my account becomes delinquent, I understand I am responsible to pay actual and reasonable collection charges and/or attorney fees. _____ Initial

I, _____ (patient name, if over age 18, or responsible party name), give permission to Mid Atlantic Neurology to give medical treatment. I have the right to discuss all medical treatments with my provider. I have the right to refuse any procedure or treatment.

SIGNATURE: _____ DATE: _____

PHARMACY: _____ LOCATION: _____ PHONE# _____

THE PATIENT CONSENTS TO THE PROVIDER IMPORTING THEIR PRESCRIPTION INFORMATION FROM THEIR PHARMACY. _____ Initial

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DATE: _____ NAME: _____ AGE: _____

WT: _____ HT: _____ BP: _____ PUL: _____ REP: _____

REFERRING PHYSICIAN: _____

REASON FOR VISIT: _____

MEDICAL HISTORY

ALLERGIES / ADVERSE DRUG REACTIONS (PLEASE LIST THE SIDE EFFECTS)

CURRENT MEDICATIONS:

PAST MEDICAL HISTORY

Please circle all that apply to you and your immediate family. (Mother, father, siblings, grandparents, aunts/uncles etc)

	SELF	FAMILY		SELF	FAMILY
Diabetes	Yes / No	Yes / No _____	Hypertension	Yes / No	Yes / No _____
Headaches	Yes / No	Yes / No _____	Sleep Apnea	Yes / No	Yes / No _____
Seizures	Yes / No	Yes / No _____	Head Injury	Yes / No	Yes / No _____
COPD/Emphysema	Yes / No	Yes / No _____	Asthma	Yes / No	Yes / No _____
PTSD	Yes / No	Yes / No _____	Cancer	Yes / No	Yes / No _____
Kidney Stones	Yes / No	Yes / No _____	Anemia	Yes / No	Yes / No _____
Herniated Disc	Yes / No	Yes / No _____	Arthritis	Yes / No	Yes / No _____
Ulcers	Yes / No	Yes / No _____	Irregular Heartbeat /Palpitations	Yes / No	Yes / No _____

OTHER: _____

SURGICAL HISTORY

SOCIAL HISTORY

Caffeine Use (Circle One): Yes / No If Yes, # _____ Drinks Per: (Circle One) Day / Week / Month

Smoking Status (Circle One): Never / Occasionally / Daily / Former - Quit Date: _____

If Yes, # _____ Packs Per: (Circle One) Day / Week / Month

Alcohol Use: (Circle One) Yes / No # _____ Drinks Per (Circle One) Day / Week / Month Quit Date: _____

Recreational Drug Use: Yes / No # _____ Times Per (Circle One) Day / Week / Month Quit Date: _____

Exercise: Yes / No How Often? _____ Type: _____

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CHECK ALL THAT APPLY:

General:

- Weight Loss
- Weight Gain
- Fatigue
- Fevers

Eyes:

- Double Vision
- Blurred Vision
- Dry Eyes
- Vision Loss

Ear, Nose, Throat:

- Ringing in Ears
- Chronic Sore Throat
- Nose Bleeds
- Hoarseness

Pulmonary:

- Shortness of Breath
- Wakes up short of breath

Cardiac:

- Chest Pain
- Leg Swelling
- Irregular Heartbeat /Palpitations

Gastrointestinal:

- Constipation
- Diarrhea
- Abdominal Pain
- Vomiting
- Bowel Incontinence

Skin:

- Rashes
- Skin Discoloration
- Hair Changes

Genitourinary:

- Frequent Urination
- Pain in Urination
- Bladder Incontinence
- Erectile Dysfunction

Neurological:

- Chronic Headache
- Seizures
- Strokes / TIA
- Loss of Balance
- Vertigo
- Chronic Numbness
- Tremors
- Loss of Consciousness
- Speech Difficulties
- Swallowing Difficulties
- Arm Weakness
- Leg Weakness

Musculoskeletal:

- Neck Pain
- Muscle Aches and Pain
- Joint Swelling
- Joint Pain
- Chronic Back Pain

Psychiatric:

- Depression
- Anxiety
- Traumatic Event
- Paranoia
- Suicidal Thoughts

Lymph:

- Easy Bruising
- Easy Bleeding

Sleep:

- Daytime Sleepiness
- Restless Legs
- Snore
- Violent Dreams
- Insomnia
- Stop Breathing at Night
- Hallucinations

Any other Neurological symptoms related to your referral.

Dominant hand?

- Right
- Left
- Ambidextrous

Do you have a pacemaker?

- Yes
- No

Are you currently pregnant?

- Yes
- No

Have you ever been on seizure medication?

- Yes
- No

Have you ever had a:

- CT Head
- MRI Brain
- MRI Spine
- Nerve Conduction
- Lumbar Puncture
- Carotid Doppler
- Sleep Study

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AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient's Name: _____ Date of Birth: _____

I, _____ authorize Mid Atlantic Neurology & Sleep Medicine to release my medical and/or billing information to the following individual(s):

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing at any time.

Signature: _____ Date: _____