Neurology Consultants of Montgomery, P.C.

PATIENT INFORMATION SHEET

Referred by :__________________ **Primary Care Physician**______________

Social Security Number ____________________ **Date of Injury or Illness:** ____________________

First Name ____________________ **MI** _____ **Last Name** ____________________ **Title** ________

Date of Birth ____________________ **Current Age** ________ **Male** _____ **Female** _____ **Race** __________

Marital Status: __ Married __ Single __ Divorced __Widowed **Spouse Name:**____________________

Address ____________________ **City** ____________________ **State** ______ **Zip Code** ________

Home Telephone Number ______________ **Work Telephone Number** ______________ **Cell Telephone #** ______________ **E-Mail Address** ______________

Patient's Employer ____________________ **Employers Address, City, State and Zip Code** ____________________

Occupation: ____________________

Please indicate who we may speak with regarding your protected health information (PHI)

____

May we leave messages for you regarding your PHI or your appointment: Yes _____ **No** _____

Emergency Contact Name(s) ____

Relationship ____________________ **Home Telephone Number** ____________________ **Work Telephone Number** ____________________

Present Complaint – Why are you here today? ____

Are you a resident of a nursing home or an assisted living facility? ______**Yes** ______**No**

If yes, which one? ____

PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES.

I hereby authorize Neurology Consultants, to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Neurology Consultants, for any insurance benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees and/or court costs. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e. MRI's or Ultrasounds). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

____________________________________ ____________________

Patient/Responsible Party Signature Date

Payment of co-payment is expected at the time of service. Check ____ Credit Card ____ Cash ____

Medicine list: (all prescription, over the counter, and herbal medicines)

For Office Use

BP: **P:** **R:**

REVIEW OF SYSTEMS:

Recent weight loss?	___NO	___YES
Fever?	___NO	___YES
Decrease in vision?	___NO	___YES
Double vision?	___NO	___YES
Glaucoma?	___NO	___YES
Cataracts?	___NO	___YES
Swallowing difficulty?	___NO	___YES
Speech difficulty?	___NO	___YES
Ringing in the ears?	___NO	___YES
Hearing loss?	___NO	___YES
Cough?	___NO	___YES
Shortness of breath?	___NO	___YES
Chest pain?	___NO	___YES
Heart racing?	___NO	___YES
Indigestion?	___NO	___YES
Diarrhea?	___NO	___YES
Constipation?	___NO	___YES
Vomiting?	___NO	___YES
Abdominal pain?	___NO	___YES
Nausea?	___NO	___YES
Kidney problems?	___NO	___YES
Bladder problems?	___NO	___YES
Impotence?	___NO	___YES
Incontinence?	___NO	___YES
Back pain?	___NO	___YES
Neck pain?	___NO	___YES
Arthritis?	___NO	___YES
Skin Rash?	___NO	___YES
Breast changes?	___NO	___YES
Numbness?	___NO	___YES
Weakness?	___NO	___YES
Dizziness/vertigo?	___NO	___YES
Depression?	___NO	___YES
Hallucinations?	___NO	___YES
Sinus trouble?	___NO	___YES
Food Allergy?	___NO	___YES
Difficulty sleeping?	___NO	___YES
Snoring?	___NO	___YES

Other ____

SOCIAL HISTORY:

Smoking History: ________Never smoked.

________Former smoker, quit_____ years ago. Smoked _____ packs per day for _____ years.

________Currently smoke ______ packs per day for _____ years.

Alcohol History: ________None

________Drinks per day(beer, wine, or whiskey) _______ days per week

DRUG ALLERGIES:____

Which drug store do you use? ________________________________

Pharmacy phone number: ________________________________