NEW PATIENT INFORMATION

Tallahassee Neurological Clinic – Department of Neurology (Dr. Ortiz & Dr. Martin - EMG)

Today's Date _____ Have you ever been seen in this office before today's visit? _____

Patient Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Soc. Sec. # _____ Gender _____ Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Name of Referring Physician/Agency _____

Name of PCP or Family Physician _____

Responsible Party ☐ Self ☐ Spouse ☐ Parent ☐ Other

Responsible Party Name _____ Phone _____

Address _____

Date of Birth _____ SS# _____

In Case of Emergency, please notify _____

Address _____ Relationship _____ Phone _____

Insurance Information

Reason for today's visit ☐ Illness ☐ Auto Accident ☐ Job Injury ☐ Other Injury

- If auto accident, please **notify receptionist immediately**
- If job injury, please complete Worker's Comp section below
- If other injury, date & brief description _____

1. Primary Health Ins. Co. _____

   Address _____

   Insured's Name _____ DOB _____ Soc. Sec. # _____

   Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

   Policy # _____ Group # _____

2. Seconday Health Ins. Co. _____

   Address _____

   Insured's Name _____ DOB _____ Soc. Sec. # _____

   Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

   Policy # _____ Group # _____

3. Worker's Comp. Ins. Co. _____

   Address _____ Date of Injury _____

   Adjuster Name _____ Phone _____ Claim # _____

I have completed this form entirely and certify that I am the patient or duly authorized agent of the patient to furnish the information requested. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered.

Patient/Resp Party Signature _____ **Date** _____

New Patient – History Information

Tallahassee Neurological Clinic – Department of Neurology

Patient Name _____

DOB _____

Doctor _____

1. What is the primary reason you are coming to see the doctor?_____

   _____

   _____

2. Describe your problem, onset, symptoms, and duration _____

   _____

   _____

3. List ALL medication you are taking with the dose and frequency.

   1. _____ 4. _____
   2. _____ 5. _____
   3. _____ 6. _____

4. List ALL medication allergies and the reaction that they cause.

   1. _____
   2. _____
   3. _____
   4. _____

5. Please list one pharmacy (name and location) to which doctors can fax your prescriptions and refills

   _____

6. Please provide history of any family medical problems

   ☐ Cancer If yes, who:_____What type? _____
   ☐ Stroke/CVA/TIA If yes, who:_____
   ☐ Hypertension If yes, who:_____

7. Does anyone in your family suffer from any neurological disease or disorders?_____

   _____

8. Are you right or left handed? _____
9. How many children do you have? _____ Are they healthy? _____
10. List the doctors (and their locations) seen in the past year for this same problem. _____

    _____

11. Are you currently working? _____ If so, where? _____

Patient signature _____ Date _____

Acknowledgement of Privacy Statement, Authorization and Assignment of Benefits

Patient's Name (please print) _____ Date of Birth_____

Guarantor's Name (please print)_____ Date of Birth_____
(*if patient is a minor or dependent)*

PRIVACY STATEMENT

I acknowledge receipt of the **Notice of Privacy Practices** pamphlet from Tallahassee Neurological Clinic, P.A. I understand that it is my responsibility to read the information provided therein.

Signature_____ Date _____
(If patient is a minor or dependent, parent or legal guardian must sign)

APPOINTMENTS AND PRESCRIPTIONS

If patient is a minor or dependent, all parents or legal guardians must be listed below

Should it become necessary, the following people have my permission to schedule, confirm, cancel or reschedule an appointment for me. They may also pick up prescriptions, refills, samples, or anything that I have requested from Tallahassee Neurological Clinic, P.A. **No medical information will be given**. **I understand that if I need to change this information, it is my responsibility to request this in writing.**

1. Name _____ Relationship _____
   Phone No. _____ ( ) Home ( ) Work ( ) Cell
2. Name _____ Relationship _____
   Phone No. _____ ( ) Home ( ) Work ( ) Cell

Signature_____ Date _____
(If patient is a minor or dependent, parent or legal guardian must sign)

RELEASE OF MEDICAL INFORMATION

Should it become necessary, Tallahassee Neurological Clinic Physicians and medical staff have my permission to discuss my health information, including test results, with the individuals listed below. The people that are listed below are also authorized for the above statement regarding appointments and prescriptions. **I understand that if I need to changes this information, it is my responsibility to request this in writing.**

1. Name _____ Relationship _____
   Phone No. _____ ( ) Home ( ) Work ( ) Cell
2. Name _____ Relationship _____
   Phone No. _____ ( ) Home ( ) Work ( ) Cell

Signature_____ Date _____
(If patient is a minor or dependent, parent or legal guardian must sign)

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical or other information necessary to process the insurance claim(s) for services rendered by Tallahassee Neurological Clinic, P.A. I request payment of government benefits, if applicable, to the party who accepts assignment. I authorize payment of medical benefits to Tallahassee Neurological Clinic, P.A. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered.

Signature_____ Date _____
(If patient is a minor or dependent, parent or legal guardian must sign)