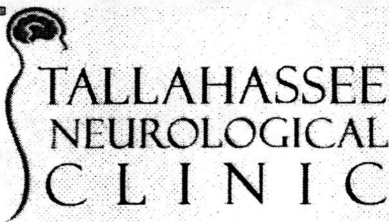

NEW PATIENT INFORMATION

Tallahassee Neurological Clinic- Department of Neurosurgery

Name: ______________________________ **Birth Date:** ____________________
Last First Middle

Social Security #: ______________________________ **Gender:** ☐ Female ☐ Male

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Address: ____

City: ____________________ State: ______________ Zip: ______________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ Email: ____________________

Referring/Requesting Physician: ____________________ Phone: ____________________

Primary Care Physician: ____________________ Phone: ____________________

Contact Person in case of emergency: ____________________________________

Relationship to contact: ____________________ Contact Phone: ____________________

Insurance Information

***** Please give all insurance cards to the receptionist at the front desk*****

Was this related to an accident? ☐ Yes ☐ No If yes, ☐ Auto ☐ Work ☐ Other ____________________

If this was related to an accident, Date of Injury ______________

I have completed this form completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services. Assignment of Benefits: I authorize payment of Medical benefits to Tallahassee Neurological Clinic for services rendered by any physician of Tallahassee Neurological Clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

Signature of Patient or Responsible Party: ______________________________ *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

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.**

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

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 change this information, it is my responsibility to request this in writing.**

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

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)

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TALLAHASSEE NEUROLOGICAL CLINIC, P.A.
Department of Neurosurgery
HISTORY INTAKE FORM

Name:_________________________ Date of Birth:________________ Date:____________

Dominant Hand (circle one): **RIGHT** **LEFT**

Requesting Physician:____

Primary Care Physician:____

Reason for Visit:____

How long have you had this problem? ____

Have you had any of the following treatments for this:
_____ pain medications?
_____ epidural injections?
_____ physical therapy?
_____ surgery?

(Physician use Only):

____
____
____
____

Do you have any **ALLERGIES** to medications? **NO** **YES** **If yes, to what?**

____

What kind of reaction did you have?____ _

Are you taking daily **Aspirin**, **Coumadin** or **Plavix** (blood thinners) or **Diuretics** (blood pressure medication)? **Yes** **No**

Current PAIN Medications	**Dosage**	**How Often**	**Prescribed by**

Other Prescribed Medications	**Dosage**	**How Often**	**Prescribed by**