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WELCOME TO OUR OFFICE!

PLEASE BE ADVISED THAT YOUR FIRST VISIT IS FOR AN
INITIAL CONSULATION ONLY.

YOU AND THE DOCTOR WILL DECIDE ON THE BEST TREATMENT PLAN FOR YOU.

INSTRUCTIONS

- Please call us to verify that we have received your records from your referring physician. This is necessary for your appointment.
- Please do NOT bring children to your appointment. The doctor needs your undivided attention at this visit. Please call us to reschedule if you do not have alternate care for your child.
- A complete exam will take approximately 30-60 minutes depending on your problem. A report will be sent to your referring physician.
- We work strictly by appointment. If we experience any delays, we will keep you informed.
- Bring your current medications in the bottle for our doctors to verify the name and dose prescribed.

FEES

Consultations range in price depending on the complexity of the examination, diagnosis and treatment options, and time involved. Please note that we accept insurance assignment for Medicare, Medicaid, Blue Cross, Worker's Comp and some HMO's (contact us to verify our participation with your plan). **For us to file insurance for auto accident cases, you must bring all billing information with you. If there is an attorney involved in your case, please notify the receptionist.**

If you have any questions regarding our office or policies, please call us at (850)877-5115.

TO ASSIST YOU IN YOUR VISIT TO OUR OFFICE, WE ARE MAILING THESE FORMS PRIOR TO YOUR VISIT. PLEASE FILL THEM OUT AND BRING THEM WITH YOU TO THE APPOINTMENT. ALSO BRING YOUR INSURANCE CARDS AND YOUR CO-PAY. THIS WILL BE REQUIRED AT CHECK-IN.

Please feel free to call us if you need assistance completing these forms. If you cannot fill out the forms prior to your visit, please **come 1 hour ahead of your appointment time so we may help with their completion.**

THANK YOU FOR YOUR COOPERATION!
WE LOOK FORWARD TO SEEING YOU ON:

DATE:_____**TIME:**_____

DOCTOR:_____

NEW PATIENT INFORMATION

Tallahassee Neurological Clinic- Department of Neurosurgery

Name: _____ Birth Date: _____

Last First Middle

Social Security #: _____ Gender: ☐ Female ☐ Male

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Other of Undetermined

Preferred Language: _____ Race: _____

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

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

How do you want to receive appointment reminders? ☐ Phone Call ☐ Text Message ☐ 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 _____

If this was related to an auto accident were you treated within 14 days of the accident: ☐ Yes ☐ No

If yes, where were you treated? _____

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:* _____

Tallahassee Neurological Clinic
Department of Neurosurgery
History Intake Form

NAME:_____ Date of Birth:_____ Date:_____

Referring Physician:_____ **Primary Care Physician:**_____

Dominant Hand (Circle one): Right Left **Reason for visit:** _____

How long have you had this problem? _____

Was this problem related to an accident? YES NO

If yes, choose: AUTO WORK OTHER:_____ Date of injury:_____

If this was an auto accident were you treated within 14 days of the accident? YES NO

If yes, where were you treated?_____

Have you had any of the following treatments for this (check all that apply)?

_____Pain Management _____epidural injections _____ physical therapy _____surgery

Physician use only:_____

_____

Do you have any medication allergies? NO YES If yes, to what?

_____ Reaction:_____

_____ Reaction:_____

_____ Reaction:_____

Are you taking daily Aspirin, Coumadin or Plavix (blood thinners) or Diuretics (blood pressure medication)? YES NO

What medications are you taking? Include over the counter medications and supplements

Medication	Dosage	How often	Prescribed by

Today's Date: _____

Name: _____ **Date of Birth:** _____

REVIEW OF SYMPTOMS – DEPARTMENT OF NEUROSURGERY

Please circle all that apply to your health **today**.

GENERAL - fever, chills, loss of appetite, weight loss, fatigue, **NONE**

EYES - vision loss 1 eye, vision loss both eyes, double vision, blurring, light sensitivity, **NONE**

EAR, NOSE & THROAT- ringing in the ears, ear discharge, decreased hearing, difficulty swallowing, hoarseness, **NONE**

HEART - near fainting, chest pain or discomfort, racing or skipping of heart beat, lightheadedness, shortness of breath with exertion, palpitations, swelling of hands or feet, difficulty breathing while lying down, leg cramps with exertion, **NONE**

LUNGS- shortness of breath, chest discomfort, wheezing, **NONE**

STOMACH & BOWELS- loss of appetite, nausea, vomiting, diarrhea, constipation, dark tarry stools, bloody stools, **NONE**

BLADDER & KIDNEYS- blood in urine, urinating frequently, unable to empty bladder, urgency to urinate, pain with urination, unable to control bladder, **NONE**

MUSCLES & BONES- muscle cramps, back pain, neck pain, stiffness, muscle weakness, loss of strength, **NONE**

SKIN- excessive perspiration, dryness, skin cancer, rash, **NONE**

NEURO- difficulty with concentration, poor balance, headaches, disturbances in coordination, numbness, unable to speak, falling down, tingling, brief paralysis, visual disturbances, seizures, weakness, sensation of the room spinning, tremors, fainting, excessive daytime sleeping, memory loss, **NONE**

PSYCH- sense of great danger, anxiety, mental problems, depression, **NONE**

ENDO- excessive hunger, cold intolerance, heat intolerance, excessive urination, excessive thirst, **NONE**

BLOOD- abnormal bleeding, abnormal bruising, **NONE**

ALLERGY- infections that won't go away, seasonal allergies, HIV exposure, HIV, **NONE**

Authorization & Assignment of Benefits, Medical Release Information, Privacy Statement

Patient's Name**:** _____ Date of Birth**:** _____

Emergency contact, Release of Medical Information,

Prescription pick up and Appointment Information

Tallahassee Neurological Clinic physicians, and medical staff have my permission to discuss my health information, including test results, schedule confirm, cancel or reschedule my appointments, and pick up prescriptions, samples, refills or anything that I have requested from Tallahassee Neurological Clinic, P.A., with the individuals listed below. I am denoting specific approvals next to each individual listed. **If patient is a minor, ALL parents, or legal guardians must be listed below.**

1) Name:_____ Relationship: _____

Phone No.: _____ ( ) Home ( )Work ( ) Cell

Emergency contact: ( )yes ( )no **Medical info**: ( )yes ( )no **Appointment info**: ( )yes ( )no **Prescriptions**: ( )yes ( )no

2) Name:_____ Relationship: _____

Phone No.: _____ ( ) Home ( )Work ( ) Cell

Emergency contact: ( )yes ( )no **Medical info**: ( )yes ( )no **Appointment info**: ( )yes ( )no **Prescriptions**: ( )yes ( )no

Accident Relationship to Visit

Is this visit related to an accident? Yes No If yes: ( ) Auto ( ) Work ( ) Other _____

If yes: Date of injury: _____ If Auto were you treated within 14 days of accident? Yes no

If yes, where were you treated? _____

Privacy Statement

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

Authorization and Assignment of Benefits

I authorized 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. Furthermore, I verify that all information provided by me on this document is accurate to the best of my knowledge at this time and that this information is good for one year from date of signature unless I request changes in writing.

Signature: _____ Date: _____