NEW PATIENT INFORMATION

Tallahassee Neurological Clinic – Department of Neurology

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. # _____ Marital Status _____ Gender: _____

Preferred Language: _____ Race: _____ Email Address: _____

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino □ Other or Undetermined

Preferred Method of Contact for Appointment Reminder: □ Phone □ Email □ Text Message

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 _____

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/Worker Comp □ Other Injury

Date of Accident ____/____/_____ Date of Injury ____/____/_____

Workers Compensation Co. Name: _____

Claim Number: _____ Adjuster's Name and Phone Number: _____

Auto Insurance Name: _____ Policy/Claim Number: _____

Primary Health Ins. Co. _____

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

Relationship to Patient □ Self □ Spouse □ Parent □ Other

Policy # _____ Group # _____

Secondary Health Ins. Co. _____

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

Relationship to Patient □ Self □ Spouse □ Parent □ Other

Policy # _____ Group # _____

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.

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

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, P.A. has my permission to: discuss my **health information, including test results, schedule, confirm, cancel or reschedule my appointments, pick up prescriptions, samples, refills** with the individuals listed below.

If patient is under 18, parent(s) or legal guardian(s) must be listed on this form.

1) Name: _____ Relationship: _____

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

2) Name: _____ Relationship: _____

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

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.

Telephone Consumer Protection Act (TCPA)

I agree, in order to service my account or to collect monies I may owe, Tallahassee Neurological Clinic, P.A., and/or our agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. TNC and/or agents of TNC may also contact me by sending text messages or emails, using the email address I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that Tallahassee Neurological Clinic, P.A., its employee and/or agents may contact me/us as described above.

Authorization to Review Prescription History

I agree, in order to assure that my medication history is accurate, Tallahassee Neurological Clinic physicians, and medical staff have my permission to retrieve historically prescribed medication in the past year via Dr. First Medication Management.

Signature: _____ Date: _____

New Patient – History Information

Tallahassee Neurological Clinic – Department of Neurology

Patient Name: _____

Date of Birth: _____ Age: _____

Doctor: _____

1. What is the primary reason you are coming to the Doctor?

   _____

   _____

2. Describe your problem, onset symptoms and duration.

   _____

   _____

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

   1._____ 4. _____

   2. _____ 5. _____

   3._____ 6. _____

4. List ALL medication allergies and the reaction 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 list ALL of your previous surgeries, including minor surgeries along with the year.

   1. _____

   2. _____

   3. _____

   4. _____

   5. _____

7. Please list ALL of your medical problems, including such things as heart, lung and kidney problems and medical problems such as diabetes, cancer, high blood pressure, etc.

   1._____ 5. _____

   2. _____ 6. _____

   3. _____ 7. _____

   4. _____ 8. _____

Patient Signature: _____ Date: _____