NEW PATIENT INFORMATION

Tallah	assee Neu	irological (Clinic – De	partmer	nt of Neurology	
Today's Date:	Have you	ever been see	en in this of	fice befor	e today's visit?	
Patient Name	Patient Name Date of Birth					
Address				City/Stat	te/Zip	
Soc. Sec. #		Marital	Status		Gender:	
Preferred Language:		Race:		Emai	l Address:	
Ethnicity: □ Hispanic or I	Latino 🗆 N	Ion-Hispanic	or Latino	Other o	or Undetermined	
Preferred Method of Con	ntact for A	ppointment	Reminder	<u>:</u> □ Ph	one 🗆 Email 🗆 Tex	t Message
Home Phone	v	Vork Phone _			_ Cell Phone	
Employer		(Decupation _			
Name of Referring Physic	ian/Agency	У				
Name of PCP or Family P	hysician					
Responsible Party	Self		□Pa	rent	Other	
Responsible Party Name _				Pł	10ne	
Date of Birth				S	SS#	
In Case of Emergency, ple	ase notify					
Address		Relations	ship		Phone	
Insurance Information						
Reason for today's visit:	□ Illness	Auto Ac	cident	🛛 Job Inju	ry/Worker Comp	□ Other Injury
D	ate of Acc	ident/_	/	Dat	te of Injury/_	/
Workers Compensation	Co. Name	:				
Claim Number:		Adjuster's N	ame and Ph	one Num	ber:	
Auto Insurance Name: _		Poli	cy/Claim N	umber: _		
Primary Health Ins. Co.						
Insured's Name		DOB		_Soc. See	c. #	
Relationship to Patient	□ Self		□ Parent		her	
Policy #			Group #			
Secondary Health Ins. Co						
Insured's Name		DOB		_Soc. Sec	c. #	
Relationship to Patient	□ Self		□ Parent		her	
Policy #			_Group # _			
I have completed this for patient to furnish the info			that I am t	the patie	nt or duly authoriz	ed agent of the

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 <u>health information</u>, <u>including test results, schedule, confirm, cancel or reschedule my appointments, pick up</u> <u>prescriptions, samples, refills</u> 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 medications in the past year via Dr. First Medication Management.

Signature: _____

Date: _____

New Patient – Additional Information

Tallahassee Neurological Clinic - Department of Neurology

Patient Name: ______

Date of Birth: _____

Doctor: _____

- 1) Please list on pharmacy (name and location) to which doctors can fax your prescriptions and refills.
- 2) Please list any tests that have been completed within the past year such as MRI's, MRA's, CT Scan, EEG, EMG, Doppler, Labs, Blood work.

Please list month/year and facility where tests were completed

3) List the doctors (and their locations) seen in the past year for this <u>same problem.</u>

1.	
2.	
3.	
4.	

Patient Signature:	Date:	

Tallahassee Neurological Clinic Department of Neurology History Intake Form

Date: TNC Neurologist:
Patient Name: DOB:
Family Doctor:
What is the primary reason you are coming to see the doctor?
Please describe your problem, including the onset, symptoms, and duration:
Spinal Injuries

Have you ever had an injury to your back or neck? If so, please describe:

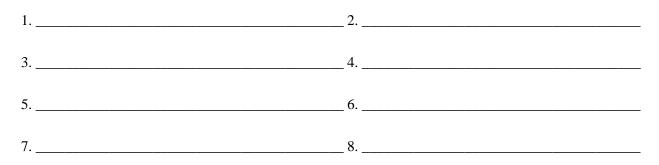
Past Surgical History

Please list <u>all</u> of your previous surgeries, including minor surgeries, along with the year and surgeon who did the operation

1.	 	 	
2			
2.	 	 	
3.	 	 	
4.	 	 	
5.			

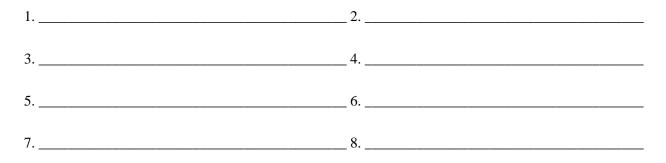
Past Medical History

Please list <u>all</u> your medical problems, including such things as heart, lung, and kidney problems and medical problems such as diabetes, cancer, high blood pressure, etc.



Medications

Please list <u>all</u> medications you are taking, including over-the-counter medicines such as aspirin, etc., along with the dose and frequency of the medication. (**Bring medicine bottles to appointment.**)



History Intake Form (cont'd,) Allergies

Please list <u>all</u> allergies to medication <u>and the reaction</u> you have with the medicine.

1	2			
3	4			
5				
Social	History			
Right or Left Handed				
How many children do you have?	Are they healthy?			
If not healthy, what diseases do they suffer?				
Have you ever or do you now smoke?	If so, how long and how much?			
If you were a previous smoker, when did you stop a	nd how long did you smoke?			
Do you drink alcohol? If so, how	much and how frequently?			
If you drank alcohol previously, when did you stop and how long did you drink?				
Do you now or have you ever used any illegal drugs	5?			
Family	/ History			
Is your mother alive? If not, of what and	at what age did she die?			
Is your father alive? If not, of what and at what age did he die?				
How many brothers and sisters	do you have?			
Please list their medical problems.				
Has anyone in your family suffered cancer or a neur	cological disease? Please list:			

Review of Systems

Please select all that apply to you or that you notice.

General - Recent weight loss, recent weight gain, weakness, fatigue, fever

Skin – Rashes, lumps, sores, itching, dryness, changes in nails, changes in hair

Head – Headache, head injury

Eyes - Visual loss, pain, redness, double vision, excessive tearing

Ears - Hearing log, ringing in ears, earaches, ear infections, drainage from ears

Nose and Sinuses - Nasal stuffiness, nasal discharge, nosebleeds

Mouth and Throat – Bleeding gums, loss of teeth, sore tongue, sore throat, sores on gums, sores inside mouth

Neck - Lumps in neck, "swollen glands", goiter

Breasts - Lumps, pain or discomfort, nipple discharge

Respiratory - Cough, coughing up blood, wheezing, asthma, bronchitis

Cardiac - Heart trouble, heart murmurs, chest pain, palpitations, rheumatic fever

Gastrointestinal – Swallowing troubles, heartburn, nausea, vomiting, vomiting of blood, change in bowel habits, rectal bleeding, abdominal pain, liver troubles

Urinary - Frequent urination, burning with urination, incontinence, stones, infection

Peripheral Vascular - Leg cramps, varicose veins, clots in legs

Neurological - Fainting blackouts, seizures, tremors, involuntary movements, strokes

Hematological - Anemia, easy bruising, excessive bleeding, transfusion reactions in past

Endocrine - Thyroid trouble, excessive sweating, diabetes, excess thirst, excess hunger

Psychiatric – Nervousness, tension, depression, any history of psychiatric problems

Please do not write below this line

BP	Pulse	Resp	Temp	Weight	
		x	x	C	
Physiciar	n Signature		I	Date	