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 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 **all** of your previous surgeries, including minor surgeries, along with the year and surgeon who did the operation

1. _____

2. _____

3. _____

4. _____

5. _____

Past Medical History

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

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Medications

Please list **all** 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.)**

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

History Intake Form (*cont'd,*)

Allergies

Please list **all** allergies to medication and the reaction you have with the medicine.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

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 and 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? _____

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 neurological disease? Please list:

_____

_____

Patient Signature: _____ **Date:** _____

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

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Please do not write below this line

BP _____ Pulse _____ Resp. _____ Temp. _____ Weight _____

Physician Signature _____ Date _____