MID ATLANTIC NEUROLOGY & SLEEP MEDICINE, PA

PATIENT INFORMATION

SSN: ______________________________

PATIENT NAME: ______________________________ DOB: ______________ SEX: M / F

ADDRESS: ______________________________ STATE: ________ ZIP: __________

PHONE #'S: (HOME) ________________ (CELL) ________________ (WORK) ________________

E-MAIL: ______________________________ PREFERRED METHOD OF CONTACT: HOME / CELL / WORK

MARITAL STATUS (CIRCLE ONE): SINGLE / MARRIED / SEPARATED / DIVORCED / WIDOWED

RACE (CIRCLE): CAUCASIAN / AFRICAN AMERICAN / ASIAN / NATIVE (INDIAN) AMERICAN / HISPANIC / OTHER ____________

(If patient is under the age of 18): NAME OF RESPONSIBLE PARTY ________________ DOB: __________ SSN: __________

INSURANCE INFORMATION

PRIMARY: ______________________________ SUBSCRIBER: ______________________________

ID#: ______________________________ GROUP#: ______________________________

SUBSCRIBER'S DOB: ____________ SSN: ______________ RELATIONSHIP TO PATIENT: ______________

SECONDARY: ______________________________ SUBSCRIBER: ______________________________

ID#: ______________________________ GROUP#: ______________________________

SUBSCRIBER'S DOB: ____________ SSN: ______________ RELATIONSHIP TO PATIENT: ______________

EMERGENCY CONTACTS: Please circle whether they are authorized to receive medical information under HIPAA. YES / NO

NAME: ______________________________ RELATIONSHIP: ______________ PHONE#: ______________

NAME: ______________________________ RELATIONSHIP: ______________ PHONE#: ______________

NAME: ______________________________ RELATIONSHIP: ______________ PHONE#: ______________

All professional services rendered are charged to the patient. The necessary forms will be completed to expedite insurance carrier payments. I give permission to Mid Atlantic Neurology to release my health information to the insurer to receive payment. The patient is responsible for all charges, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. _____ **Initial**

In the event my account becomes delinquent, I understand I am responsible to pay actual and reasonable collection charges and/or attorney fees. _____ **Initial**

I, ______________________________ (patient name, if over age 18, or responsible party name), give permission to Mid Atlantic Neurology to give medical treatment. I have the right to discuss all medical treatments with my provider. I have the right to refuse any procedure or treatment.

SIGNATURE: ____ **DATE:** ______________

PHARMACY: ______________________ **LOCATION:** ______________________ **PHONE#** ____________

THE PATIENT CONSENTS TO THE PROVIDER IMPORTING THEIR PRESCRIPTION INFORMATION FROM THEIR PHARMACY. __________ Initial

MID ATLANTIC NEUROLOGY & SLEEP MEDICINE, PA

DATE: ______________________ NAME: ____ AGE: ____________

WT: ________________ HT: ________________ BP: ________________ PUL: ________________ REP: __________________

REFERRING PHYSICIAN: ____

REASON FOR VISIT: ____

MEDICAL HISTORY

ALLERGIES / ADVERSE DRUG REACTIONS (PLEASE LIST THE SIDE EFFECTS)

____

____

CURRENT MEDICATIONS:

____

____

____

PAST MEDICAL HISTORY

Please circle all that apply to you and your immediate family. (Mother, father, siblings, grandparents, aunts/uncles etc)

	SELF	FAMILY
Diabetes	Yes / No	Yes / No ________
Headaches	Yes / No	Yes / No ________
Seizures	Yes / No	Yes / No ________
COPD/Emphysema	Yes / No	Yes / No ________
PTSD	Yes / No	Yes / No ________
Kidney Stones	Yes / No	Yes / No ________
Herniated Disc	Yes / No	Yes / No ________
Ulcers	Yes / No	Yes / No ________

	SELF	FAMILY
Hypertension	Yes / No	Yes / No ________
Sleep Apnea	Yes / No	Yes / No ________
Head Injury	Yes / No	Yes / No ________
Asthma	Yes / No	Yes / No ________
Cancer	Yes / No	Yes / No ________
Anemia	Yes / No	Yes / No ________
Arthritis	Yes / No	Yes / No ________
Irregular Heartbeat /Palpitations	Yes / No	Yes / No ________

OTHER: ____

____

SURGICAL HISTORY

____

____

____

SOCIAL HISTORY

Caffeine Use (Circle One): Yes / No If Yes, #________ Drinks Per: (Circle One) Day / Week / Month

Smoking Status (Circle One): Never / Occasionally / Daily / Former - Quit Date: ____________________

If Yes, #________ Packs Per: (Circle One) Day / Week / Month

Alcohol Use: (Circle One) Yes / No #_______ Drinks Per (Circle One) Day / Week / Month Quit Date: __________

Recreational Drug Use: Yes / No #_______ Times Per (Circle One) Day / Week / Month Quit Date: ____________

Exercise: Yes / No How Often? ____________________________ Type: ______________________________

MID ATLANTIC NEUROLOGY & SLEEP MEDICINE, PA

CHECK ALL THAT APPLY:

General:
- Weight Loss
- Weight Gain
- Fatigue
- Fevers

Eyes:
- Double Vision
- Blurred Vision
- Dry Eyes
- Vision Loss

Ear, Nose, Throat:
- Ringing in Ears
- Chronic Sore Throat
- Nose Bleeds
- Hoarseness

Pulmonary:
- Shortness of Breath
- Wakes up short of breath

Cardiac:
- Chest Pain
- Leg Swelling
- Irregular Heartbeat /Palpitations

Gastrointestinal:
- Constipation
- Diarrhea
- Abdominal Pain
- Vomiting
- Bowel Incontinence

Skin:
- Rashes
- Skin Discoloration
- Hair Changes

Genitourinary:
- Frequent Urination
- Pain in Urination
- Bladder Incontinence
- Erectile Dysfunction

Neurological:
- Chronic Headache
- Seizures
- Strokes / TIA
- Loss of Balance
- Vertigo
- Chronic Numbness
- Tremors
- Loss of Consciousness
- Speech Difficulties
- Swallowing Difficulties
- Arm Weakness
- Leg Weakness

Musculoskeletal:
- Neck Pain
- Muscle Aches and Pain
- Joint Swelling
- Joint Pain
- Chronic Back Pain

Psychiatric:
- Depression
- Anxiety
- Traumatic Event
- Paranoia
- Suicidal Thoughts

Lymph:
- Easy Bruising
- Easy Bleeding

Sleep:
- Daytime Sleepiness
- Restless Legs
- Snore
- Violent Dreams
- Insomnia
- Stop Breathing at Night
- Hallucinations

Any other Neurological symptoms related to your referral.

____
____
____
____
____
____
____
____

Dominant hand?
- Right
- Left
- Ambidextrous

Do you have a pacemaker?
- Yes
- No

Are you currently pregnant?
- Yes
- No

Have you ever been on seizure medication?
- Yes
- No

Have you ever had a:
- CT Head
- MRI Brain
- MRI Spine
- Nerve Conduction
- Lumbar Puncture
- Carotid Doppler
- Sleep Study