COMPREHENSIVE NEUROLOGY, P.A.

PATIENT INFORMATION

PATIENT'S NAME:_____ BIRTH DATE:_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME TEL. NUMBER:_____ MOBILE TEL. NUMBER: _____

MARITAL STATUS: □SINGLE □MARRIED □PARTNERED □DIVORCED □WIDOWED

DO YOU AUTHORIZE THIS OFFICE TO COMMUNICATE WITH YOU BY E-MAIL? □YES □NO

IF YES, PLEASE PROVIDE E-MAIL ADDRESS:_____

IN CASE OF EMERGENCY, PROVIDE NAME, RELATIONSHIP AND TEL. NUMBER OF PERSON TO CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE#:_____

NAME OF PRIMARY CARE PROVIDER:_____

NAME AND LOCATION OF PHARMACY: _____

REFERRED BY? □PHYSICIAN □HOSPITAL □FRIEND □WEBSITE/GOOGLE □HEALTH INSURANCE

INSURANCE INFORMATION

NAME OF **PRIMARY** INSURANCE: _____

SUBSCRIBER ID#: _____

GROUP# (IF APPLICABLE): _____

NAME OF **PRIMARY** GUARANTOR: _____

BIRTH DATE OF GUARANTOR: _____

RELATIONSHIP TO PATIENT: _____ ADDRESS OF GUARANTOR IF DIFFERENT:

_____

NAME OF **SECONDARY** INSURANCE: _____

SUBSCRIBER ID#: _____

GROUP# (IF APPLICABLE): _____

NAME OF **SECONDARY** GUARANTOR: _____

BIRTH DATE OF GUARANTOR: _____

RELATIONSHIP TO PATIENT: _____ ADDRESS OF GUARANTOR IF DIFFERENT:

_____

PERSONAL MEDICAL HISTORY

PATIENT'S NAME:_____ BIRTH DATE:_____

Briefly describe **MAIN** concern: _____

DATE OF INJURY / SYMPTOM ONSET: _____/_____/_____

CHECK (✓) WHICH APPLY TO YOUR SYMPTOMS:

☐WORK RELATED INJURY ☐RECURRENCE OF PREVIOUS INJURY ☐INJURY RELATED TO FALLING
☐MOTOR VEHICLE ACCIDENT ☐INJURY RELATED TO LIFTING ☐RECENT HOSPITALIZATION
☐CAUSE UNKOWN ☐ATHLETIC/RECREATIONAL INJURY ☐OTHER:_____

☐DIABETES
☐ARTHRITIS
☐CHEST PAIN/ANGINA
☐HIGH BLOOD PRESSURE
☐HEART DISEASE
☐HEART ATTACK
☐HEART PALPITATIONS
☐PACEMAKER
☐HEADACHES/MIGRAINES
☐KIDNEY PROBLEMS
☐CANCER
☐OSTEOPOROSIS
☐BOWEL/BLADDER PROBLEMS
☐NEUROPATHY/NERVE INJURY
☐ASTHMA/BREATHING PROBLEMS
☐LIVER/GALLBLADDER PROBLEMS
☐ SMOKING
☐ STROKE/CVA

☐RHEUMATOLOGIC DISORDERS
☐DIETARY RESTRICTIONS RELATED TO HEALTH
☐GASTRIC BYPASS/SLEEVE SURGERY
☐HEAT/COLD INTOLERANCE
☐NIGHT SWEATS
☐HERNIA
☐SEIZURES
☐METAL IMPLANTS
☐DIZZINESS/FAINTING
☐RECENT FRACTURES
☐SURGERIES
☐SKIN DISORDERS
☐SEXUAL DYSFUNCTION
☐NAUSEA/VOMITING
☐RINGING IN YOUR EARS
ANY OTHER NOT LISTED:_____
_____
_____

ANY ALLERGIES TO MEDICINES? ☐NO KNOWN ALLERGIES ☐ALLERGIES (PLEASE LIST ON NEXT LINE):

_____

CURRENT MEDICATIONS: (PLEASE CHECK ✓ ALL THAT APPLY)

☐ASPIRIN DAILY
☐MEDICATION FOR BLOOD PRESSURE CONTROL
☐MEDICATION FOR ASTHMA MANAGEMENT
☐MEDICATION FOR DIABETES MANAGEMENT
☐MEDICATION FOR HEART DISEASE
☐CANCER CHEMOTHERAPY
☐HIV MEDICATION
☐ANTIBIOTICS
☐MULTI-VITAMINS
☐OVER-THE-COUNTER HEADACHE MEDICINE
☐PRESCRIPTION MIGRAINE MEDICINE
☐STEROIDS
☐SLEEP MEDICINES

☐HEPATITIS MEDICINES
☐KIDNEY MEDICINES
☐HERBAL SUPPLEMENTS
☐MEDICINES FOR ALZHEIMER'S DISEASE
☐ADHD OR ADD MEDICINES (STIMULANTS)
☐MEDICINES FOR DEPRESSION
☐OTHER PSYCHIATRIC MEDICINES
☐MEDICINE FOR SMOKING CESSATION
☐METHADONE
☐SUBOXONE
☐SKIN CREAMS
☐MEDICATIONS FOR RHEUMATOLOGIC DISORDERS
☐MEDICATIONS FOR SEASONAL ALLERGIES

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING ANY INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR THE PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE OFFICE AND MY DOCTOR OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:_____DATE:_____