Advanced Neurology

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social security #	Sex: __ Male __ Female
Home Address:	City:	State: Zip:
Home #:	Cell#:	Work#:
Email Address:		
Marital Status: __Single __Married __Divorced __Separated __Widowed		
Employment Status: __Full Time __Part Time __Not Employed __Self Employed __Retired __Military		

RACE, ETHNICITY & LANGUAGE INFORMATION

Race:	__ White __ African American/Black __ Hispanic __ Asian __ Other __ Refused
Ethnicity:	__ Hispanic/Latino __ Not Hispanic/Latino __ Other_____ __ Refused
Language:	__ English __ Spanish __ Other _____

Emergency Contact

Name:	Phone#:	Relationship:

Health Insurance Information

Primary Insurance Company:	
Policy Holder Name:	Relationship to Patient:
Member ID#:	Group#:
Policy Holder Date of Birth: / /	
Secondary Insurance Company:	
Policy Holder Name:	Relationship to Patient:
Member ID#:	Group#:
Policy Holder Date of Birth: / /	

Prescription Insurance Information

Name and Phone number:			
Rx ID#:	RxBIN:	RxPCN:	RxGrp:

IS THIS VISIT RELATED TO AN AUTO ACCIDENT OR WORKER'S COMP CLAIM? ____YES ____NO

If you answered yes to the above question, we regret to inform you we will not be able to see you.

PRIMARY CARE DOCTOR:
REFERRING DOCTOR:

_____ _____

Signature of Patient / Legal Representative Date

Patient Name _____ Date of Birth _____

PAST MEDICAL HISTORY

Please check ALL that apply and list date(s) of diagnosis if known.

___ Abdominal / Aortic Aneurysm
___ Addison's Disease
___ Alzheimer's Disease
___ Anemia
___ Angina
___ Anxiety
___ Arthritis
___ Asthma
___ Atrial Fibrillation / Flutter
___ Benign Positional Vertigo
___ Bipolar Disorder
___ Blindness
___ Blood clot or clotting disorder
Type: _____
___ Brain hemorrhage
When? _____
___ Cancer
Type? _____
___ Cardiac murmur
___ Carotid disease
___ Cataracts
___ Cirrhosis of liver
___ Colitis
___ Congestive Heart Failure
___ COPD / Bronchitis / Emphysema
___ Crohn's Disease
___ Dementia
___ Depression
___ Diabetes Mellitus Type 1
___ Diabetes Mellitus Type 2
___ DVT (deep venous thrombosis)
___ High cholesterol
___ Epilepsy
___ Essential / Familial tumor
___ Fibromyalgia
___ GERD (acid reflux)
___ GI hemorrhage
___ Glaucoma
___ Gout
___ Hallucination/Delusion
___ Head trauma
When? _____
___ Headaches
___ Heart disease
___ Heart attack?
Age? ___
___ Hemorrhoids
___ Hepatitis
___ High blood pressure
___ HIV
___ Hydrocephalus
___ Hyperthyroidism
___ Hypothyroidism
___ Urinary incontinence
___ Bowel incontinence
___ Intracranial / Brain aneurysm
___ Intracranial / Brain tumor
___ Irregular heartbeat
___ Jaundice
___ Kidney failure
___ Kidney stones
___ Liver failure
___ Back pain
Where? _____
___ Low platelet count
___ Lyme disease
___ Macular degeneration
___ Meningitis
___ Mitral valve prolapse
___ Multiple sclerosis
___ Myasthenia gravis
___ Osteoporosis / Osteopenia
___ Parkinson's disease
___ Parkinsonism
___ Peptic ulcer (stomach / jejunal)
___ Peripheral neuropathy
___ PFO
___ Pneumonia
___ Psoriasis
___ PTSD
___ Restless legs
___ Seizures
___ Severe headaches
___ Migraines
___ Sleep apnea
___ Stroke
___ Syncope
___ STD
What type? _____
___ Thyroiditis
___ TIA
___ Trigeminal neuralgia
___ Tuberculosis
___ UTIs
___ Vertigo/dizziness
___ Visual problems
___ Walking difficulty

___ Frequent falls
___ Hearing Aids
___ Wear glasses
___ Wear contacts

___ Other:

CONSENT TO SHARE CONFIDENTIAL MEDICAL/BILLING INFORM

Patient's Legal Name:_____ Patient's Date of Birth: ___

I HEREBY AUTHORIZE ADVANCED NEUROLOGY LLC TO SHARE ANY RELEVANT MEDICAL INFORMATION REGARDING THE ABOVE-NAMED PATIENT, INCLUDING BUT NOT LIMITED TO, INFORMATION ABOUT APPOINTMENT TIME, DATE AND REASON FOR VISIT, BILLING INFORMATION, MEDICATIONS AND MEDICAL INFORMATION WITH THE FOLLOWING PEOPLE:

FULL NAME_____ DOB_____ RELATIONSHIP_____

FULL NAME_____ DOB_____ RELATIONSHIP_____

I understand that I may cancel this consent at any time in writing to Advanced Neurology, LLC but that canceling it will not affect any information that has already been released.

Patient Signature:_____ Date:_____

MEDICARE MEDICAL BENEFICIARIES PLEASE SIGN BELOW

Statement to permit payment of benefits from Medicare to provider, physicians, and patients

I request that payment of authorized benefits be made to either me or on my behalf for any services furnished to me by Advanced Neurology Dr. Mahmood Alnahass, including physician services. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefit related services.

_____ _____ _____

Name of Beneficiary | Medicare / HICN# | Medigap / Supplement ID#

_____ _____

Signature of Beneficiary | Date

FINANCIAL POLICY

Please initial each line and sign below

_____ I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statement, promptly upon presentment, unless credit arrangements are made prior with the billing department.

_____ I hereby authorize the assignment of any insurance benefits and agree to be liable for any remaining Balance not paid by insurance or other benefits. In addition to the remaining balance, I agree to pay all collection costs and reasonable fees in the event the delinquent account is turned over to our attorneys or collection agency.

_____ I authorize the release of any medical or other information necessary to process claims.

_____ I authorize Advanced Neurology LLC to communicate appointment reminders and general messages through all provided points of contact, which may include U.S. mailing addresses, e-mail addresses and/or telephone numbers/voicemail.

_____ I understand that I will be charged a no-show fee of $125 for new patients and $75 for established patients if I do not give 24 hours advance notice of cancellation.

_____ I have been given the opportunity to review Advanced Neurology's Notice of Privacy Practices.

_____ I understand it is my responsibility to submit documentation if I have a Power of Attorney.

_____ I have been given the opportunity to review Advanced Neurology's financial policy and I agree to abide by its guidelines.

_____ _____ _____

Signature of responsible party | Relation to patient | Date

To comply with Government standards & improve our record keeping, it is important that you fill out this form a so that we may gather information in a more meaningful way for your treatment & care.

Patient Name _____ Date of Birth: _____

Pharmacy Name, Phone#, City/State: _____

Referring Physician name, Phone#, City/State: _____

Primary Care Physician name, Phone#, City/State: _____

SOCIAL HISTORY

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Current smoker? ☐No ☐Yes ____ packs per day for ____ years

Former smoker? ☐No ☐Yes ____ packs per day for ____ years When did you quit? _____

Do you drink alcoholic beverages? ☐No ☐Yes If yes, ___ quantity & how often _____

Drug use? ☐No ☐Yes If yes, please list _____

Education: ☐High school ☐Trades school ☐College ☐Other _____

Exercise regularly? ☐No ☐Yes Sexually active? ☐No ☐Yes Practice safe sex? ☐No ☐Yes

Do you live alone? ☐No ☐Yes If no, please list the name & relationship _____

GYNECOLOGICAL HISTORY

Date of last menstrual _____ How many children? _____

____Total # pregnancies ____Full term ____Pre-term ____Living ____Miscarriages

____Menopausal ____Postmenopausal ____Premenopausal

IMMUNIZATIONS/PROCEDURES

Approximate date (MO/YR) of last Influenza Vaccine _____ ☐Declined ☐Never received
Approximate date (MO/YR) of last Pneumonia Vaccine _____ ☐Declined ☐Never received
Approximate date (MO/YR) of last Colonoscopy _____ ☐Declined ☐Never received
Approximate date (MO/YR) of last Mammogram _____ ☐Declined ☐Never received
Approximate date (MO/YR) of last Pap smear _____ ☐Declined ☐Never received

Do you have **ALLERGIES** to medication?

_____ _____ _____
_____ _____ _____
_____ _____ _____

Patient Name _____ Date of Birth _____

FAMILY HISTORY

Check all that apply	Mother		Father		Sister		Brother		Daughter		Son		MGM		MGF		PGM		PGF	
Health status (A) alive (D) deceased	*A*	*D*	*A*	*D*	*A*	*D*	*A*	*D*	*A*	*D*	*A*	*D*	*A*	*D*	*A*	*D*	*A*	*D*	*A*	*D*
Alzheimer's disease																				
Arthritis/Joint pain																				
Atrial fibrillation																				
Bleeding disorder																				
Blood clots/clotting disorder																				
Brain malignancy																				
Cancer What type?																				
Coronary artery disease																				
Dementia																				
Diabetes Mellitus Type 1 or type 2																				
Elevated cholesterol																				
Epilepsy / Seizures																				
Headaches / Migraines																				
Heart attack/MI age																				
Heart Disease																				
High blood pressure																				
Intracranial/Brain aneurysm																				
Intracranial/brain tumor																				
Mental/Emotional Illness																				
Miscarriages																				
Movement disorder																				
Multiple Sclerosis																				
Muscle weakness/disease																				
Nerve disease																				
Parkinson's disease																				
Stroke/TIA age																				
Thyroid diseases																				
Tremors																				
Other Family history not mentioned:																				

Patient Name _____ Date of Birth _____

PAST SURGICAL HISTORY

Please check ALL that apply and list date(s) of surgery if known:

___ Abdominal surgery
___ Aortic aneurysm repair
___ Aortic valve replacement
___ Appendectomy surgery
___ Bariatric surgery (gastric bypass surgery)
___ Bilateral tubal ligations
___ Bone fracture surgery
___ Brain tumor resection
___ Breast biopsy
___ Breast removal (mastectomy)
___ Cancer biopsy
___ Cancer resection
___ Carotid endarterectomy
___ Carotid stent placement
___ Carpal tunnel release
___ Cataract extraction
___ Cerebral angiogram
___ Cervical surgery:
    ___ Microdiscectomy
    ___ Spinal fusion
    ___ Spinal laminectomy
___ Cesarean section
___ Cholecystectomy (gallbladder)
___ Coronary angiogram
___ Coronary angioplasty
___ Coronary bypass surgery/CABG
___ Coronary stent placement
___ Craniectomy/Craniotomy
___ Detached retina surgery
___ Dilation and curettage
___ Foot surgery
___ Hip arthroplasty surgery
___ Hip replacement surgery
___ Hysterectomy surgery
___ Inguinal hernia repair surgery
___ Intracranial aneurysm clipping/coiling
___ Knee arthroplasty procedure
___ Knee surgery/replacement
___ LASIK surgery
___ Lithotripsy for kidney stones
___ Lumbosacral surgery:
    ___ Microdiscectomy
    ___ Spinal fusion
    ___ Spinal laminectomy
___ Lung surgery
___ Mitral valve replacement
___ Nasal septum surgery
___ Nephrectomy (kidney resection)
___ **Pacemaker/Defibrillator placement**
___ PEG tube placement
___ Prostate resection
___ Radiation therapy
___ Rotator cuff repair surgery
___ Shoulder reconstruction
___ Sinuses surgery
___ Skin cancer resection
___ Spinal stimulator insertion
___ Subdural hematoma removal
___ Tonsillectomy/adenoid resection
___ Thoracic surgery:
    ___ Microdiscectomy
    ___ Spinal fusion
    ___ Spinal laminectomy
___ TURP for prostate
___ Ulnar nerve release
___ Uvuloplasty
___ Vasectomy procedure
___ VP shunt placement
___ Wrist surgery

___ Others