Neurological Associates

PATIENT INFORMATION

Patient

Date: _____

Name: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Email address: _____

Patient's occupation: _____ Employer: _____

Employer's address: _____ Employer phone: _____

Spouse's name: _____ Spouse's DOB: _____ Spouse's SSN: _____

Spouse's occupation: _____ Employer: _____

Employer's address: _____ Employer phone: _____

In case of emergency, notify: _____ Relationship: _____

City: _____ State: _____ Phone: _____

If patient is a minor, list person/s other than emergency contact above who have permission to bring child to office for treatment:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Insurance *(provide patient information unless patient is a minor, then provide guarantor's information)*

PRIMARY INSURANCE

Insurance name: _____ Relationship to patient: _____

Subscriber's name: _____ Copay amount: _____

Subscriber ID/Contract Policy #: _____ Group #: _____

Subscriber's SSN: _____ Subscriber's DOB: _____

Subscriber's Employer: _____ Employer's Phone: _____

SECONDARY INSURANCE

Insurance name: _____ Relationship to patient: _____

Subscriber's name: _____ Copay amount: _____

Subscriber ID/Contract Policy #: _____ Group #: _____

Subscriber's SSN: _____ Subscriber's DOB: _____

Subscriber's Employer: _____ Employer's Phone: _____

Person responsible for this account: _____ Phone: _____

I agree payment will be made at the time of service. I agree to pay all co0pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carries to release information to HH Physician Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physician all payments for medical services rendered to myself or my dependents if assignment applies.

_____ _____ _____

Signature Date Time

Neurological Associates

MEDICAL HISTORY WORK-UP SHEET

Date: _____ Chart #: _____

Name: _____ Date of birth: _____ Age: _____

Reason for visit: _____

What are your main concerns or questions today? _____

_____

Description of present illness (include when your symptoms started): _____

_____

PAST MEDICAL HISTORY *(Please check if you have any of the below.)*

- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Anemia
- ☐ Anxiety
- ☐ Autoimmune Disease (Lupus)
- ☐ Biliary Cirrhosis
- ☐ Bipolar Disorder
- ☐ Blood Transfusion
- ☐ Brain Tumor
- ☐ Cirrhosis
- ☐ CVA/Stroke
- ☐ COPD (Lung Disease)
- ☐ Colon Cancer
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Chronic Kidney Disease
- ☐ Depression
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Diverticulitis
- ☐ DVT (Blood Clot in Legs)
- ☐ Eczema
- ☐ GI Bleed
- ☐ Gerd (Acid Reflux)
- ☐ Hemochromatosis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Goiter
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Infertility
- ☐ Insomnia
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ MI (Heart Attack)
- ☐ Migraine Headaches
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ PUD (Stomach Ulcers)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Nodule
- ☐ Tuberculosis
- ☐ Valvular Heart Disease
- ☐ UTI - Recurrent
- ☐ Varicose Veins/Phlebitis
- ☐ Abnormal Pap Smear
- ☐ Breast Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Gestational Diabetes
- ☐ Rh Sensitized
- ☐ Sleep Apnea

Using a CPAP? Yes / No

Other_____

PAST SURGICAL HISTORY

- ☐ Amputation
- ☐ AV Fistula Creation
- ☐ AV Graft
- ☐ Aortic Valve Replacement
- ☐ Aortic Valve Replaced
- ☐ Appendectomy
- ☐ Both Legs Bypassed
- ☐ Back Surgery
- ☐ Bronchoscopy (Lung Scope)
- ☐ CABG (Heart Bypass)
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel Right / Left
- ☐ Cataract Extraction
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Gallbladder Removed
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement Right / Left
- ☐ Invasive Pain Procedure
- ☐ Kidney Transplant Right / Left
- ☐ Knee Arthroscopy Right / Left
- ☐ Knee Replacement Right / Left
- ☐ Kyphoplasty
- ☐ Mitral Valve Replaced
- ☐ Nephrectomy Right / Left
- ☐ Pacemaker Implanted
- ☐ Parathyroidectomy
- ☐ Pneumonectomy Right / Left
- ☐ PTCA (Angioplasty)
- ☐ Rotator Cuff Repair Right / Left
- ☐ Abdominal Hysterectomy
- ☐ Ovaries Removed Yes / No
- ☐ Prostate Surgery
- ☐ Shoulder Surgery Right / Left
- ☐ Sleep Apnea Surgery
- ☐ Thyroid Surgery
- ☐ Tonsil's Removed
- ☐ Vascular Surgery
- ☐ Breast Augmentation Right / Left
- ☐ Mastectomy Right / Left
- ☐ Lumpectomy Right / Left

Other_____

Patient name: _____ DOB _____

FAMILY HISTORY	Father	Mother	Brother	Sister	Children
High Blood Pressure	☐	☐	☐	☐	☐
Heart Artery Disease/Heart Attack	☐	☐	☐	☐	☐
Kidney Disease (Chronic)	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Cancer (Type)	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐
Tumors	☐	☐	☐	☐	☐

SOCIAL HISTORY *(Check or circle appropriate)*

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Work ☐ Part-Time ☐ Full-Time ☐ Retired ☐ Disabled Occupation:_____

Children: Yes / No Religious Affiliation _____

ALLERGIES OR MEDICATION REACTIONS ☐ **NO KNOWN DRUG ALLERGIES**

Allergic to: Reaction:

_____

_____

_____

RISK FACTORS *(Check or circle appropriate)*

☐ Current tobacco use Year started _____

Type of tobacco: Cigarettes / Cigars / Snuff / Vapor

☐ Former tobacco use Year quit _____

☐ Never smoked

Second hand smoke Yes / No

Do you wear a seat belt? Yes / No

Multiple sexual partners? Yes / No

Caffeine Use Yes / No

How many drinks per day _____

Alcohol use Yes / No

How many per day? _____ Type _____

Exercise Yes / No

Times per week _____ Type _____

CURRENT MEDICATIONS ☐ **REFER TO LIST** ☐ **REFER TO BOTTLES**

Please include the dose and how often you take the medication. *(Skip if you brought a list or bottles)*

Name	Dosage	How many times per day?	As Needed (PRN)

Patient name: _____ DOB _____

Pharmacy _____ Phone # _____ Location _____

Do we have permission to receive medication history on patient via electronic prescription? Yes / No

Signature of patient/guardian _____ Date _____

NEUROLOGICAL PROBLEMS Have you had any recent or persistent problems with the following?

- ☐ Headache
- ☐ Dizziness/vertigo
- ☐ Passing out
- ☐ Confusion
- ☐ Concentration
- ☐ Memory issues
- ☐ Personality change
- ☐ Hallucinations
- ☐ Speech difficulty
- ☐ Tremers/shakes
- ☐ Nausea/vomiting
- ☐ Trouble with smell
- ☐ Other visual changes
- ☐ Difficulty chewing/ swallowing/choking
- ☐ Difficulty tasting
- ☐ Facial numbness/ tingling
- ☐ Drooling
- ☐ Hoarseness
- ☐ Weakness, location: _____
- ☐ Numbness, location: _____
- ☐ Stiffness
- ☐ Clumsiness
- ☐ Pain
- ☐ Poor balance
- ☐ Incontinence - bladder
- ☐ Incontinence - bowel
- ☐ Other: _____ _____ _____

OTHER MEDICAL PROBLEMS Have you had any recent or persistent problems with the following?

General
- ☐ Weight Gain/Loss
- ☐ Fever/Chills/Fatigue
- ☐ Snoring
- ☐ Sleep Troubles
- ☐ Depression/Anxiety

Neuro
- ☐ Headache
- ☐ Head injury
- ☐ Blackouts/Dizzy
- ☐ Seizures/Tremors
- ☐ Memory Loss
- ☐ Numbness/Tingling
- ☐ Forgetfullness/ Confusion
- ☐ Abnormal Coordination

ENT
- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Glasses/Contacts
- ☐ Blurred Vision
- ☐ Ringing
- ☐ Hoarseness
- ☐ Runny Nose
- ☐ Hearing Loss
- ☐ Trouble Swallowing
- ☐ Neck Lump
- ☐ Swollen Glands
- ☐ Earache

Heart
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Ankle Swelling

Lungs
- ☐ Persistent Cough
- ☐ Cough Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Musculoskeletal
- ☐ Joint Pain
- ☐ Gout
- ☐ Varicose Veins
- ☐ Leg Swelling
- ☐ Back Pain
- ☐ Joint Stiffness
- ☐ Muscle Weakness
- ☐ Muscle Pain
- ☐ Muscle Cramps

Gastrointestinal
- ☐ Reflux/GERD
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody/Black Stool
- ☐ Hemorrhoids
- ☐ Loss of Appetite
- ☐ Rectal Bleeding
- ☐ Abdominal Pain

OTHER MEDICAL CIRCUMSTANCES Please check all that apply.

- ☐ Pacemaker or defibrillator
- ☐ Recent stents, coils or filters
- ☐ Nerve stimulator
- ☐ Cochlear (ear) implant
- ☐ Pain pump
- ☐ Metal in eye
- ☐ Shrapnel or bullet
- ☐ Diaphragm or IUD
- ☐ Transdermal (skin) patch
- ☐ Body piercings
- ☐ Pregnant
- ☐ *Kidney disease
- ☐ *Liver or kidney transplant
- ☐ Aneurysm clips
- ☐ Bone growth stimulator
- ☐ Heart valve prosthesis
- ☐ Insulin pump
- ☐ Hearing aids
- ☐ Penile prosthesis
- ☐ Tattoos or tattooed eyeliner
- ☐ Braces or removable dental item
- ☐ Artificial limb or joint
- ☐ Tissue expander
- ☐ *On dialysis
- ☐ *Diabetes
- ☐ *Hypertension

PRIOR HOSPITALIZATIONS (reasons): _____

_____

Neurological Associates

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ SSN (opt):_____

Date of Birth: _____ Address:_____

Phone: _____ Date of Service: _____

Chart #: _____

Provider: _____

I authorize the use or disclosure of the above named individual's health information as described below:

- Huntsville Hospital Physician Network is authorized to make the disclosure.
- The type and amount of information to be sued or disclosed is as follows: (include dates where appropriate)
  - ☐ All/entire record
  - ☐ Visit/encounter notes
  - ☐ Laboratory results
  - ☐ X-ray and imaging reports
  - ☐ Problem list
  - ☐ Medication list
  - ☐ Allergies list
  - ☐ EKG report
  - ☐ Pathology report
  - ☐ Consultation report
  - ☐ Operative report
  - ☐ Immunization record
  - ☐ Drug and alcohol treatment
  - ☐ HIV/AIDS/STD treatment
  - ☐ Registration record
  - ☐ Other: _____

  Records release format:
  (choose one)
  - ☐ e-delivery (HealthPort connect)
  - ☐ CD
  - ☐ Paper
- I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndroms (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- This information may be disclosed to and used by the following individual or agency:

  Name: _____ Address: _____

  for the purpose of: _____
- I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless otherwise revoked, the authorization will expire on the following date, event or condition:

  _____

  If left blank, this authorization will expire six months from the date of signing.
- I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
- I understand as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.
- I understand I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits. HOWEVER, I understand that if I refuse to sign this form, under specific conditions the organization can refuse treatment enrollment in the health plan and/or eligibility for benefits.

_____ _____ _____
Signature Date Time

_____
Relationship to patient (if signed by legal representative)

_____ _____ _____
Signature of witness Date Time

OFFICE USE ONLY: Any portion of the record request found in paper chart? ☐ Yes ☐ No

Neurological Associates

132 REQUEST FOR HEALTH INFORMATION FROM HOSPITALS OR OTHER PROVIDERS

Name of Organization/Person _____

Address _____

Fax/Phone _____

Huntsville Hospital requests information for the following patient:

Patient Name_____

SS# (Optional)_____ Date of Birth _____

Address _____

Phone _____

Signature _____ Date of Service _____

Patient Number: _____

Requested information for treatment, payment or operations:

- ☐ Discharge summary
- ☐ History and physical
- ☐ Operative note
- ☐ Pathology report
- ☐ Consultation report
- ☐ EKG report
- ☐ Nurses' notes
- ☐ Progress notes
- ☐ Physicians' orders
- ☐ Outpatient record
- ☐ Emergency dept record
- ☐ Laboratory results
- ☐ Imaging results
- ☐ Other: _____

_____

_____

_____

_____

Please send to:

Huntsville Hospital Neurological Associates
Fax: (256) 265-6386

_____ _____

Signature Date

_____ _____

Relationship to patient Witness

ROI32A

HUNTSVILLE HOSPITAL / Medical District