Your Name: ___________________________ Email Address: _________________

Date of Birth: _________________ Age: ________ Social Security #:______________________________

Address: ____

City: _________________ State: ______________ Zip Code: _____________________________

Home #:___________________ Cell#:__________________ Work#:_____________________

Sex: F or M Marital Status: S M Wid Sep Div Spouse's Name: _______________________

Emergency Contact: ______________________________ Telephone #____________________

Primary Doctor's Name: ________________________

Referring Physician's Name: ______________________

Insurance Name: ____________________________

ID#:______________________________ Group#: ______________________________

Office Policies you should know:

A. **Please alert our office of any insurance or address changes**
B. We are not Medicaid providers; if your secondary insurance is Medicaid you will be responsible for your annual Medicare deductible.
C. Tests done outside our office (Blood, X-ray, CT-Scan, MRI, etc) may take up to 2 weeks or longer for results. If you have not received a call back in two weeks, please call our office.
D. Co-payments, co-insurances and deductibles are due at the time of service; otherwise your appointment will be rescheduled.
E. Please be aware that we are not your insurance company; therefore, we have limited Insurance benefit information. If you have any questions about your insurance benefits, please contact the 1-800 numbers listed on your ID card. Thank you.
F. **If you are an HMO patient, you will need an authorization or referral from your primary care physician or referring physician for every visit. It is your responsibility to make sure the referral is faxed, mailed, and/or brought to our office by the date of your appointment.** Without the referral you will be responsible for all services. New patient visits are $325 follow-up visits are $140.
G. **If you are here due to a car accident we will need the claim number from your car insurance, claim address, and the phone number to the claim representative.** Your health insurance does not cover these charges until your car insurance has processed the charges.
H. We welcome your suggestions or complaints about our office. You may submit any suggestions or complaints by mail at 9090 SW 87 CT. suite 200 Miami, FL 33176 Att: Practice Manager or by e-mail at Iclark@neuroscienceconsultants.com
I. For any medication refill please have the pharmacy fax us the request to 305-596-0657 at least 72 hours in advance.
J. If you would like a copy of these policies, please ask the clerks.
K. The office also had a no show fee for $25 per visit.

Patient Signature: _________________________________ Date: ____________

Financial Agreement/ Assignment of Benefits:

I hereby authorize payment to be made directly to Neuroscience Consultants LLP of benefits due to me from my insurance company. The responsible parties agree to pay for all fees, services and treatment incurred by the patient. If there is a fee that is not covered be the insurance, this is payable by the patient. The patient also agrees to pay for all deductibles, co-payments, co-insurances and non-covered services. After receipt of a statement, if payment is not received by the next billing cycle, it is subject to a monthly finance charge. If an account is referred to an outside agency for collection, the patient agrees to pay all costs related to such action. An account will be referred to a collection service if no payment has been received within 90 days of service.

Patient or Guardian: ______________________Date:_____________

HMO and Workman compensation patient notice:

You are responsible for obtaining a referral /authorization for your visits and or testing in our offices from your primary care physician or claims adjuster.

Patient or Guardian: ______________________Date:_____________

Medical Records Release

I, ______________________________ give full authorization to discuss my medical treatment, medications, diagnosis, and/or financial information with the following Physicians and or family members only. I understand that my medical care will not be discussed with anyone that is not on this list.

_________________ __________________
Relation

__________________ __________________
Relation

__________________ __________________
Relation

___________________ _________________
Patient Signature Date

1. **What is your neurological complaint today? ________________________**

2. **CURRENT MEDICATIONS (include dose and frequency): For follow up patients, please update list.**

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

3. **PHARMACY:** **Name:** ____
Address/ZIP: ____
Phone Number: ____

4. List any other neurologist seen in the past ____

5. **YOUR PAST MEDICAL HISTORY** (Circle if appropriate. **ADD OTHERS** not listed.)

Cancer or blood disease: (List type)

Heart and Blood Vessels: Atrial fibrillation, Congestive heart failure, Coronary artery disease, Heart attack, Hypertension, Peripheral Vascular Disease, High cholesterol

Lungs: Asthma, Emphysema, Bronchitis

Kidneys: Kidney stones, Prostate enlargement, Renal failure

Psychiatric/emotional: Depression, Anxiety, Alcohol or drug addiction/treatment

Gastrointestinal: Ulcer, Liver disease, Reflux disease

Endocrine/Hormonal: Diabetes (Type 1 or 2), Thyroid disease (hypo or hyper)

Neurologic: Dementia, Parkinson's, Epilepsy, Migraine, Head trauma, Stroke, Neuropathy

List date and reason for hospitalization or surgery: ____
____

ARE YOU CURRENTLY PREGNANT or planning to become so shortly? ___________

6. **ALLERGIES:**
   a. Name of medication — Type of Reaction

_________________________________ _________________________________

_________________________________ _________________________________

   b. **Non-medication allergies:** (circle if present) Iodine, Seafood, Latex, Other (specify)

Name:______________________________ **Date:**_________________ **ECW #:** ___________

7. FAMILY MEDICAL HISTORY: (Please indicate any neurologic/cardiologic or other pertinent diseases in your family.)

Father ____

Mother ____

Siblings/Others ____

8. **SOCIAL HISTORY:** Single Married Widow Divorced Separated

Number of Children: _________

Your Occupation: _____________________________ _____ Check if retired.

Tobacco use : YES OR NO **(please circle)**

If Yes, how many cigarettes a day _________

Alcohol use (number of drinks most days):_________________________________

9. **REVIEW OF SYMPTOMS**

General:	___ Fever	**Eyes:**	___ Blurred vision
	___ Weight loss		___ Eye pain
ENT:	___ Decreased hearing	**Cardiovascular:**	___ Chest pain
	___ Ringing in ears		___ Palpitations/Heart racing
Respiratory:	___ Shortness of breath	**Gastrointestinal:**	___ Abdominal pain
	___ Cough		___ Change in bowel habits
	___ Wheezing		___ Nausea
Genitourinary:	___Frequent urination	**Muscular/Skeletal:**	___ Muscle pain
	___ Urinary incontinence		___ Swollen joints
Skin:	___ Change in hair or nails	**Psychiatric:**	___ Anxiety
	___ Rash		___ Depression
			___ Suicidal thoughts
Endocrine:	___ Temperature intolerance	**Hematologic:**	___ Easy bruising
	___ Excessive thirst		___ Swollen glands

How tall are you? ________________________ **How much do you weigh?** ________________________

10. **SLEEP COMPLAINTS**

Do you snore? _______________________________________

Are you overly sleepy during the day? _______________________________________

What time do you fall asleep? _______________________________________

What time do you wake up in the morning? _____________________________________

How many times do you wake up at night and for what reason? ____________________

Does the need to move your arms or legs prevent sleep? ___________________________

Name: ________________________________ Date: __________________ ECW #: ____________