NEUROLOGY ASSOCIATES, LLP

389 Mulberry Street - Suite 200
Macon, Georgia 31201-7904
478 – 743-9123

LAST NAME:_____ FIRST:_____ MIDDLE:_____
STREET:_____ CITY:_____ STATE:_____ ZIP:_____
MAILING ADDRESS (If Different):_____ ZIP: _____
EMAIL ADDRESS:_____ SOCIAL SECURITY NUMBER: _____
HOME #: _____ CELL #: _____
ARE YOU A FULL TIME STUDENT? _____ YES _____ NO
MALE: ___ FEMALE: ___ BIRTHDATE: _____ AGE: ___ MARITAL STATUS: _____
RACE: _____ HISPANIC ___ NON-HISPANIC ___ PREFERRED LANGUAGE:_____
PATIENT'S EMPLOYER: _____
EMPLOYER'S ADDRESS: _____ PHONE: _____

SPOUSE'S INFORMATION: NAME: _____ DOB: _____
EMPLOYER:_____ WORK #: _____ CELL #: _____

CONTACT OTHER THAN SPOUSE AND/OR GUARDIAN – NOT IN YOUR HOUSEHOLD:
NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ CELL #: _____

GUARDIAN'S NAME (IF PATIENT IS UNDER AGE 21): _____
GUARDIAN'S ADDRESS: _____ PHONE #: _____
GUARDIAN'S EMPLOYER: _____ PHONE #: _____

REFFERING PHYSICIAN: _____ PHONE #: _____
PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

IS THIS VISIT DUE TO ANY TYPE OF ACCIDENT? IF SO, PLEASE COMPLETE THIS INFORMATION.

ACCIDENT IS DUE TO: (PLEASE CIRCLE) AUTO JOB RELATED THIRD PARTY

DATE OF ACCIDENT/INJURY: _____ SYMPTOMS: _____
REASON FOR VISIT: _____

IT IS EXTREMELY IMPORTANT THAT YOU LIST THE ORDER OF YOUR INSURANCE CORRECTLY.

PRIMARY INSURANCE: _____ PPO:___ HMO: ___
INSURED (POLICY HOLDER'S NAME): _____ DATE OF BIRTH: _____
SECONDARY INSURANCE: _____ PPO: __ HMO: ___
INSURED (POLICY HOLDER'S NAME): _____ DATE OF BIRTH: _____

******** PAYMENT IS EXPECTED AT THE TIME OF SERVICE********
BE PREPARED TO PAY YOUR INSURANCE CO-PAY AT CHECK-IN

CHART #: DATE: DOCTOR/TEST:

NEUROLOGY ASSOCIATES, LLP

HAVE YOU EVER BEEN SEEN IN THIS OFFICE?	_____ YES	_____ NO
HAVE YOU EVER SEEN A NEUROLOGIST?	_____ YES	_____ NO
ARE YOU UNDER THE CARE OF HOSPICE?	_____ YES	_____ NO
DO YOU RESIDE IN A NURSING HOME?	_____ YES	_____ NO

I hereby authorize the release of any medical information necessary for payment, treatment, and healthcare operations, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information. I hereby assign and authorize payment to Neurology Associates, LLP, of all medical and/or surgical benefits, including major medical benefits, to which I am entitled under any insurance policy or policies, under any self-insured program or under any other benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Neurology Associates, LLP, by an insurance policy, self-insurance program or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

I UNDERSTAND THAT UNLESS INDICATED BELOW, NEUROLOGY ASSOCIATES, LLP, IS ALLOWED TO CONVEY PAYMENT, TREATMENT, AND HEALTHCARE OPERATIONS TO MY IMMEDIATE FAMILY - TO INCLUDE PARENTS, SPOUSE, SIBLINGS, CHILDREN (16 AND OLDER). PLEASE LIST BELOW ANY ADDITIONAL PEOPLE YOU WOULD LIKE LISTED ON YOUR ACCOUNT AS HAVING AUTHORITY TO DISCUSS YOUR PERSONAL INFORMATION IN REGARD TO TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

_____ Home Answering Machine: _____ (or) Cell Phone #: _____
_____ Significant Other/Friend: _____
_____ Other: _____

Also, list anyone you want EXCLUDED from the above:

_____ Immediate Family (to include parents, spouse, sibling, children (16 and older)
_____ Home Answering Machine: _____
_____ Other: _____

****** CONSENT TO TREATMENT AND DIAGNOSTIC PROCEDURES******

IF A PRE-CERT OR PRE-AUTHORIZATION IS REQUIRED BY MY INSURANCE COMPANY, I UNDERSTAND THAT I AM RESPONSIBLE FOR MAKING SURE THIS PRE-AUTHORIZATION IS OBTAINED. IF I AM A MEMBER OF AN HMO PLAN THAT REQUIRES NOTIFICATION OF A PRIMARY PHYSICIAN (PCP) PRIOR TO RECEIVING TREATMENT, I UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING THIS PRE-AUTHORIZATION AND FAILURE TO CONTACT MY PCP MAY RESULT IN REDUCED BENEFITS OR NON-PAYMENT.

****** PPO AND HMO******

PLEASE BE ADVISED THAT IT IS THE PATIENT'S RESPONSIBILITY TO MAKE SURE EVALUATIONS, LABS, TESTS AND REFERRALS ARE DONE WITHIN YOUR PARTICULAR NETWORK.

YOU ARE NOT OBLIGATED TO HAVE TESTING DONE AT THIS OFFICE. IF YOUR DOCTOR ORDERS A TEST AND YOU WISH TO HAVE IT DONE ELSEWHERE, PLEASE DISCUSS THIS WITH THE DOCTOR OR NURSE.

I UNDERSTAND THE ABOVE INFORMATION, AUTHORIZATION AND CONSENT TO TREATMENT BY THIS OFFICE. I UNDERSTAND THE NEUROLOGY ASSOCIATES, LLP, NOTICE OF PRIVACY PRACTICES IS AVAILABLE FOR REVIEW.

******** PLEASE COMPLETE BOTH SIDES OF THIS FORM. GIVE THIS COMPLETED FORM, YOUR INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST. BE PREPARED TO PAY YOUR INSURANCE CO-PAY AT CHECK-IN. ********

SIGNATURE: _____ DATE: _____
RELATIONSHIP TO PATIENT (IF NOT PATIENT): _____
PATIENT UNABLE TO SIGN DUE TO: _____

This form has been reviewed by: _____ Time: _____

New Patient Review of Systems

Patients Name _____

Please complete the following by completely filling in the appropriate circles.

Fever	O Yes O No	Daytime Sleepiness	O Yes O No
Weight gain of >10 lbs	O Yes O No	Snoring	O Yes O No
Weight Loss of >10 lbs	O Yes O No	Restless Leg	O Yes O No
Headache	O Yes O No	Recent Urinary Infection	O Yes O No
Double or blurred vision	O Yes O No	Urine Incontinence	O Yes O No
Slurred Speech	O Yes O No	Loss of sensation in a specific area	O Yes O No
Poor balance or falls	O Yes O No	Loss of strength in a specific area	O Yes O No
Seizures	O Yes O No	Abnormal bleeding or bruising	O Yes O No
Blackouts	O Yes O No	Any falls over the last year	O Yes O No
Trouble Swallowing	O Yes O No	Any injuries over the last year	O Yes O No
Choking	O Yes O No	Do you have pain	O Yes O No
Memory problems	O Yes O No	If so, Where? _____	
Eye Disease or Injury	O Yes O No	How severe on a scale of 1 to 10? _____	
Palpitations	O Yes O No	**Please Circle One:**	
Hearing loss	O Yes O No	Smoker	
Hearing change	O Yes O No	Current every day smoker	
Ringing or buzzing in ears	O Yes O No	Current some day smoker	
Chest Pain	O Yes O No	Former smoker	
Shortness of Breath w/ exercise	O Yes O No	(How Long O < 1 month	
Productive cough	O Yes O No	O 1 – 3 months	
Nausea	O Yes O No	O 3 – 6 months	
Bowel incontinence	O Yes O No	O 6 – 12 months	
Vomiting	O Yes O No	O 1 – 5 years	
Diarrhea	O Yes O No	O 5 – 10 years	
Constipation	O Yes O No	O > 10 years)	
Neck pain	O Yes O No	Never a smoker	
Back pain	O Yes O No	Current status unknown	
Joint pain	O Yes O No	Unknown if ever smoked	
Anxiety	O Yes O No		
Depression	O Yes O No	Height _____	
Rash	O Yes O No	Weight _____	
Heat intolerance	O Yes O No	**Flu Shot for current year**	O Yes O No
Cold intolerance	O Yes O No	**Living Will**	O Yes O No
Anemia	O Yes O No	**Durable Power of Atty for Healthcare**	O Yes O No
Sleep Apnea	O Yes O No	**Decision Maker** _____	

*ANY INPATIENT HOSPITALIZATIONS IN PAST 30 DAYS? O Yes O No

Please contact our office if you answer **Yes to either of the next two questions concerning your appointment.**

Currently in **Nursing Home** O Yes O No

Currently under the care of **Hospice** O Yes O No

Health History Patients Name_____

Please complete the following by completely filling in the appropriate circles.

Past Medical History

High Blood Pressure	O Yes	Asthma	O Yes
Diabetes	O Yes	Sleep Apnea	O Yes
Coronary Artery Disease/Angina	O Yes	Stroke	O Yes
Atrial Fibrillation	O Yes	Head Injury	O Yes
Elevated Cholesterol	O Yes	Gastric Ulcer	O Yes
Heart Pacemaker/Defibrillator	O Yes	Meningitis, Viral	O Yes
Thyroid Problems	O Yes	Acid Reflux	O Yes
Seizures	O Yes	Kidney Disease	O Yes
Headaches	O Yes	Encephalitis	O Yes
Lung Disease/Emphysema	O Yes	Cancer	O Yes
Liver Disease	O Yes		

Surgical History

Heart Angioplasty/Stenting	O Yes	Gall Bladder	O Yes
Heart Bypass	O Yes	Tonsillectomy	O Yes
Carotid Surgery	O Yes	Appendectomy	O Yes
Brain Surgery	O Yes	Defibrillator/Pacemaker	O Yes
Neck Surgery	O Yes	Cataract Removal	O Yes
Lower Back Surgery	O Yes	Tubal Ligation	O Yes
Hysterectomy	O Yes	Hip Replacement	O Yes

PLEASE LIST ANY SURGERIES NOT LISTED ON BACK: (OVER)

Social History

Marital status	O Married	O Single	O Divorced	O Separated	O Widowed
Tobacco	O Yes	O No			
Alcohol	O Yes	O No			
Drugs	O Yes	O No			
Education level reached	O H.S. Grad.	O College Grad.	O Post Grad. Education		

Family History

Mother	O Parkinson's	O Alzheimer's	O Heart Disease	O Stroke	O Epilepsy
	O Diabetes	O Migraines	O High BP	O Cancer	O
Father	O Parkinson's	O Alzheimer's	O Heart Disease	O Stroke	O Epilepsy
	O Diabetes	O Migraines	O High BP	O Cancer	O
Children	O Parkinson's	O Alzheimer's	O Heart Disease	O Stroke	O Epilepsy
	O Diabetes	O Migraines	O High BP	O Cancer	O
Brothers	O Parkinson's	O Alzheimer's	O Heart Disease	O Stroke	O Epilepsy
	O Diabetes	O Migraines	O High BP	O Cancer	O
Sisters	O Parkinson's	O Alzheimer's	O Heart Disease	O Stroke	O Epilepsy
	O Diabetes	O Migraines	O High BP	O Cancer	O

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NAME:_____**DATE:**_____

PLEASE LIST YOUR CURRENT MEDICATIONS (strength and dosages), INCLUDING ANY OVER-THE-COUNTER MEDICATIONS. FOR YOUR SAFETY, THIS FORM HAS TO BE COMPLETED AT EVERY VISIT.

_____
_____
_____
_____
_____
_____
_____

PLEASE LIST ANY DRUG, FOOD OR ENVIRONMENTAL ALLERGIES.

_____
_____
_____
_____

PLEASE LIST YOUR PHARMACY NAME AND LOCATION, INCLUDING LOCAL AND/OR MAIL ORDER.

_____
_____
_____
_____

ARE YOUR UNDER THE CARE OF HOSPICE? _____ YES _____ NO
DO YOU RESIDE IN A NURSING HOME? _____ YES _____ NO