Neurology Consultants of Montgomery, P.C.
Patient Information Sheet

Referred by:_____Primary Care Physician:_____

Social Security Number: _____

_____ _____ _____
First Name MI Last Name

_____ _____
Date of Birth Current Age Male____Female_____ Race_____

Marital Status: __Married __Single___Divorced___Widowed

_____ _____ _____ _____
Address City State Zip Code

_____
Home Number Work Number Cell Phone Number E-mail Address

Occupation_____

_____
Patient's Employer Employer's Address, City, State, and Zip Code

Are you a resident of a nursing home or assisted living facility? Yes ___ No___
If yes, which one? _____

Pharmacy: _____ Phone number: _____

Emergency Contact:

_____ _____ _____
Name Phone Number Relationship

PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOUSURE AND AGGREMENT TO PAY FOR PROFESSIONAL SERVICES.

I hereby authorize Neurology Consultants of Montgomery, PC to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment directly to Neurology Consultants, for any insurance benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, in any, I understand that I am fully responsible for any and all fees incurred and I agree the above is legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collections cost, attorney fees and/or court fees. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures(i.e. MRI's, Ultrasounds). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

I acknowledge that I have had an opportunity to review the Notice of Privacy Practices posted in the practices' office and have been given an opportunity to retain a copy of the Notice.

_____

Patient/Responsible Party Signature **Date**

Neurology Consultants of Montgomery, P.C.
PATIENT MEDICAL HISTORY

Patient Name:_____
Date of Birth: ___/___/___
Todays Date: ___/___/___

Reason for Appointment: _____

Please check circle that applies to you.

- o High Blood Pressure
- o Diabetes Mellitus
- o Hypothyroidism
- o Graves Disease
- o Pacemaker
- o Heart Bypass (CABG)
- o Congestive Heart Failure
- o Hear Arrhythmias
- o Mitral Valve Prolapse
- o Stroke
- o Hypercholesterolemia
- o Blood Cloths/DVT
- o Seizures
- o Ulcers
- o Gastrointestinal Reflux
- o Asthma
- o Bronchitis
- o Emphysema/COPD
- o Obstructive Sleep Apnea
- o Cancer
- o AIDS
- o HIV
- o Hepatitis
- o Multiple Sclerosis
- o Osteoarthritis
- o Rheumatoid Arthritis
- o Lupus/SLE
- o Restless Leg Syndrome
- o Kidney Stones
- o Nausea
- o Kidney Problems
- o Bladder Problems
- o Impotence
- o Back Pain
- o Neck Pain
- o Joint Pain
- o Skin Rash
- o Breast Changes
- o Numbness
- o Weakness
- o Dizziness
- o Hallucinations
- o Sinus Trouble
- o Blood Disorder
- o Anemia
- o Iron Deficiency
- o Osteoporosis
- o Vitamin D Deficiency
- o Migraines
- o Tension Headaches
- o Depression
- o Bipolar Disease
- o Schizophrenia
- o Failed Back Syndrome
- o Fibromyalgia
- o Cataracts
- o Glaucoma
- o Recent Weight Loss
- o Fever
- o Decrease in Vision
- o Double Vision
- o Swallowing Difficulty
- o Speech Difficulty
- o Ringing in the Ears
- o Hearing loss
- o Cough
- o Shortness of Breath
- o Chest Pain
- o Heart Racing
- o Indigestion
- o Diarrhea
- o Constipation
- o Vomiting
- o Abdominal pain
- o Difficulty Sleeping
- o Snoring
- o Memory Loss
- o Hallucinations
- o Sinus Trouble

Tobacco use:

- o Current Smoker How many: _____
- o Former Smoker
- o Never Smoked

Alcohol use:

- o Yes How often? _____
- o No

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Patient Signature:_____Date:_____

Express Prior Consent To Contact Consumer by Cell Phone:

You agree, in order for us to service your account or to collect monies you may owe, Neurology Consultants of Montgomery, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I/we have read this disclosure and agree that Neurology Consultants of Montgomery, P.C., its employees and/or agents may contact me/us as described above.

Patient Signature:_____ Date:_____

UNIVERSAL MEDICATION FORM

Fold this form and keep it in your wallet | Date form started:

Name:	Address:
Phone Number:	
Birth Date:	
Emergency Contact/Phone numbers:	

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	OTHER

Allergic To / Describe Reaction:	Allergic To / Describe Reaction:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE STARTED	NAME OF MEDICATION / DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason for Taking / Doctor Name

Refer to back of form for directions, benefits of using the form, and how to get more copies.