

# Patient Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Do you have an E-mail address? YES or NO (circle one)  
If YES, please provide it: \_\_\_\_\_ (optional)

**Chief Complaint:** What is the reason for your visit today? (Please describe problem in detail including history of present illness):

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**Past Medical History:** Please check all that apply to you:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Heart surgery             | <input type="checkbox"/> Psychiatric disease             |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> High Cholesterol          | <input type="checkbox"/> Thyroid                         |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Kidney Failure            | <input type="checkbox"/> Tuberculosis/positive skin test |
| <input type="checkbox"/> Epilepsy/seizures          | <input type="checkbox"/> Pregnancy history # _____ | <input type="checkbox"/> Other, please list              |
| <input type="checkbox"/> Heart problems: List Below | Miscarriages # _____                               |  |

**Previous Surgeries:** Please list past surgeries with approximate date:

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**Serious Injury:** Please describe any serious injuries you have had:

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**Medications:** Please list any medications (**prescribed or over the counter**) you are taking with dose and frequency:

<i>Drug</i>	<i>Dose/Frequency</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Allergies:** please list any allergies that you have and the reactions you have. Please list medications, foods and seasonal allergies.

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**Social History:**

Do you drink alcohol? Yes No If yes, how much/week? \_\_\_\_\_  
Do you use tobacco products? Yes No If yes, what kind and how many? \_\_\_\_\_  
Do you consume caffeine? Yes No If yes, how many cups/week? \_\_\_\_\_  
Do you use recreation drugs? Yes No If yes, what type and frequency? \_\_\_\_\_  
Are you on a special diet? Yes No If yes, please describe? \_\_\_\_\_

**Family History:** Do you know of any blood relative who has or had:

- |  |   |
|--|---|
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Kidney disease             |
| <input type="checkbox"/> Aneurysm                  | <input type="checkbox"/> Lung Disease               |
| <input type="checkbox"/> Brain Tumor               | <input type="checkbox"/> Migraine                   |
| <input type="checkbox"/> Cancer, Type:             | <input type="checkbox"/> Multiple Sclerosis         |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Psychiatric Disease, Type: |
| <input type="checkbox"/> Epilepsy/Seizures         | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Thyroid                    |
| <input type="checkbox"/> Heart Problems, Describe: | <input type="checkbox"/> None                       |
| <input type="checkbox"/> High blood pressure       |   |

**Comments:**

# Patient Health History

As you review the following list, please check any problems or conditions that you are experiencing or have experienced. If you do not have any of the problems listed in the section please check none.

## General Health

- Good general health
- Recent weight change
- Loss of appetite
- Fatigue
- Fever/chills

## Ears, Nose, Mouth, Throat

- Difficulty swallowing
- Earaches
- Loss of hearing/deafness
- Loss of smell
- Loss of taste
- Painful chewing
- Ringing in ears
- Sinus infection
- Sores in mouth
- None
- Other: \_\_\_\_\_

## Eyes

- Blind spots
- Blurred vision
- Double vision
- Loss of vision
- Glaucoma
- Injury
- Pain
- Other: \_\_\_\_\_
- None

## Gastrointestinal

- Blood in stools
- Increasing constipation
- Nausea
- Painful bowel movements
- Persistent diarrhea
- Stomach or abdominal pain
- Ulcer
- Vomiting
- Other: \_\_\_\_\_
- None

## Genitourinary

- Blood in urine
- Female: irregular periods
- Female: vaginal discharge
- Kidney stones
- Male: prostate disease

- Male: testicle pain
- Painful or burning urination
- Sexual difficulty
- Sexually transmitted disease
- Urgency with urination
- Urine retention
- Incontinence
- Other: \_\_\_\_\_
- None

## Heart and Lungs

- Pain in chest
- High blood pressure
- High cholesterol
- Irregular heart beat
- Other: \_\_\_\_\_
- None

## Muscles/Joints/Bones

- Back pain
- Difficulty walking
- Joint pain
- Joint stiffness or swelling
- Muscle pain or tenderness
- Neck pain
- None

## Neurological

- Balance trouble
- Black outs/loss of consciousness
- Difficulty speaking
- Difficulty walking
- Facial drooping
- Headaches
- Injury to the brain or spine
- Light-headed or dizziness
- Memory loss
- Mental Confusion
- Migraines

- Mini stroke
- Neuropathy
- Numbness or tingling
- Paralysis
- Stroke
- Tremors
- Weakness
- Other: \_\_\_\_\_
- None

Are you?  right handed  
 left handed  
 Both

## Psychiatric

- Depression
- Anxiety
- Eating disorder
- Other: \_\_\_\_\_
- None

## Pulmonary

- Asthma
- Blood in cough
- Chronic or frequent cough
- Emphysema
- Pneumonia
- Shortness of breath
- Other: \_\_\_\_\_
- None

## Skin

- Rash or itching
- Sun sensitivity
- Hair loss
- Color changes
- Other: \_\_\_\_\_
- None

## Sleep

- Snoring
  - Sleepwalking
  - Nightmares
- Do you sleep well? Yes No  
Do you feel rested when you wake? Yes No  
Do you fall asleep during the day? Yes No

Who is your primary care physician? \_\_\_\_\_

Have you had any MRI or CT scans in the past 10 years? \_\_\_Yes \_\_\_ No If yes, date and location \_\_\_\_\_

Have you had any EEG or EMG exams in the past 10 years? \_\_\_ Yes \_\_\_ No If yes, date and location \_\_\_\_\_

Are there records we need to obtain before your visit? \_\_\_Yes \_\_\_No If yes, where? \_\_\_\_\_

Have you seen a Neurologist in the past for your conditions/diagnoses? \_\_\_Yes \_\_\_No If yes, who and when \_\_\_\_\_

Please list any other physicians you see and for what conditions: \_\_\_\_\_



## Financial Policy and Authorization

Patient Name: \_\_\_\_\_

1. **Authorization for Treatment:** I hereby authorize the physician(s), physician assistant and staff of Neurology Specialists, P.C. to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medications as deemed necessary or advisable.
2. **Release of Information/Medical Record Diagnosis:** I hereby authorize the physician(s), physician assistant and staff of Neurology Specialists, P.C. to release a complete report of services rendered including diagnosis, findings and details of treatment and progress for the purpose of receiving payment for the services rendered to its authorized billing agents, my insurance carriers, employer's workers compensation insurance company, or other category of third party payer, the Social Security Administration under Title XVIII (18) of the Social Security Act, any Professional Review Organization, or other intermediaries responsible for payment of my charges. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.
3. **Authorization for Assignment of Benefits:** In consideration of medical services provided I hereby assign and transfer to the physician(s) all of my rights, title and interest to medical reimbursement in accordance with the terms and benefits under my insurance policy or other health benefits otherwise payable to me for those services rendered by my physician, including Medicare Part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full within 90 days my account will be placed for collection unless a payment plan arrangement has been made and I will be responsible for all collection expenses including reasonable attorney's fees and court costs.
4. **Insurance filing:** I understand that as a courtesy, Neurology Specialists, P.C. will file for benefits with my insurance company/companies. I understand that fees may exceed charges allowed by my insurance carrier. I agree to be responsible to Neurology Specialists, P.C. for the full balance of the charges that are not paid by my private insurance carrier including any deductible, co-payments and co-insurance.
5. **Payments at the time of Visit:** Neurology Specialists, P.C. accepts cash, checks, Visa and MasterCard. I understand that non-sufficient fund check will have a \$25 fee added to my account. I understand that my insurance policy is a contract between me and my insurance carrier. I am aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under my medical insurance plan. If my insurance carrier requires a co-payment, co-insurance or deductible the payment the payment is due at the time of service. I will also be responsible for payment of any outstanding patient balances. If I do not have health insurance coverage, I will be responsible for payment in full for my visit and any services rendered. I understand that I will be asked to pay this prior to service.
6. **Pre-certification:** If my insurance requires a pre-certification, it is my responsibility to make sure it is obtained. I will be held financially responsible if the pre-certification is not obtained.
7. **Motor Vehicle Accident:** If you are being treated for a personal injury such as a motor vehicle accident, please note that Neurology Specialists, P.C. will NOT file benefits on your behalf to an automobile insurance carrier. We also DO NOT accept attorney liens. All payments for services rendered will be expected at the time of your visit.
8. **Failed Appointments:** In the event that I do not show for a scheduled appointment without calling 24 hours in advance to cancel, I understand that I will be charged a \$50.00 fee that is non-refundable.

I hereby certify that I have read and fully understand this financial policy and authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained from any treatment.

\_\_\_\_\_  
Patient Signature/Responsible Party and relation to patient

\_\_\_\_\_  
Date

## NOTICE OF PRIVACY PRACTICES

I have received the HIPAA Notice of Privacy Practices as provided by Neurology Specialists, P.C. I understand I can request this document in entirety at any time. I understand this notice describes how my personal information is used and disclosed and how I can get access to my health information.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The people listed below have permission to receive medical information on my behalf. For example, the people listed could include family members, other physicians, insurance companies, worker comp. agencies, lawyers, etc. Please list and sign the bottom of this form. If you would not like to list anyone, simply sign at the bottom of this form.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **How may we contact you?**

Please **check** (✓) the ways in which we can contact you. Also, in the space provided, list the numbers or email addresses in which we can contact you.

\_\_\_\_\_ Home Phone # \_\_\_\_\_

\_\_\_\_\_ Work Phone # \_\_\_\_\_

\_\_\_\_\_ Cell Phone # \_\_\_\_\_

\_\_\_\_\_ Email address: \_\_\_\_\_

**Circle: YES or NO** Neurology Specialists can leave a message on my answering machines or voice mails listed above with appointment dates and times or any test results that I request the office report to me.



AUTHORIZATION TO RELEASE INFORMATION

PATIENT NAME: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

I hereby authorize the below listed physicians to release information to Neurology Specialists, P.C. This authorization will remain in force for one year (365 days) from the date signed unless revoked in writing.

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Name, address, phone and fax number of individual or organization

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Name, address, phone and fax number of individual or organization

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Name, address, phone and fax number of individual or organization

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Name, address, phone and fax number of individual or organization

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Neurology Specialists  
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Phone: (812) 330-0303  
Fax: (812) 330-0404