**North Country Neurology, P.C.**

**Patient Information Form**

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

 (FIRST) (MIDDLE) (LAST) (Jr./Sr.)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (STREET) (CITY) (STATE) (ZIP)

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

 Ok to leave

Phone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message? \_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Emergency Contact/Caretaker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

============================================================================================================

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (NAME) (ADDRESS)

Are you working? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ If not, date last worked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you retired? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ Are you totally disabled? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

============================================================================================================

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms referred here for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

============================================================================================================

**Health Insurance**

PRIMARY Name & DOB

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of Cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECONDARY Name & DOB

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of Cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MILITARY / TRICARE Insurance:

Name of Active Duty Sponsor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sponsor SS#: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Sponsor DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sponsor Rank: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Branch of Service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sponsor’s Unit & Unit Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization: I hereby authorize the processing of the Medical Insurance either by electronic or manual method by the listed North Country Neurology, P.C. My signature authorizes payment of all major medical benefits to which I am entitled from the listed insurer above to pay North Country Neurology, P.C. and/or the Provider Assignee. I further authorize North Country Neurology, P.C., to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Continue on Back)**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGE: \_\_\_\_\_\_**

**M/F Blood pressure:** \_\_\_\_\_

 **HANDEDNESS:** R/L **Pulse rate:** \_\_\_\_\_

**Current Height: \_\_\_\_ Respiratory rate \_\_\_\_\_**

**Current Weight: \_\_\_\_ Pain 0-10:** \_\_\_\_\_\_

 **DATE OF VISIT: \_\_\_\_\_/\_\_\_\_\_/20\_\_\_\_\_**

**PRESENT MEDICATIONS and Dose:**

**(Including over the counter (OTC) meds)**

**ALLERGIES/ADVERSE REACTIONS:**

**SOCIAL HISTORY:**

**Employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retired? Y/N**

**Live at home: Alone/With\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Tobacco use:** Y/N \_\_\_Packs Per Day

Start date\_\_\_/\_\_\_/\_\_\_ or Start Age:\_\_\_\_

Quit date\_\_\_/\_\_\_/\_\_\_

**Current Alcohol use:** Y/N

\_\_\_\_\_Drinks per Day/Week/Month

Drinking Alcohol Since Age:\_\_\_\_

Quit drinking at what Age:\_\_\_\_\_ or Year:\_\_\_\_\_\_

**Illicit Drug use:** Y/N

Ex. Marijuana, Cocaine, Crack, Heroin, etc.

**NOTICE OF PRIVACY PRACTICES: Acknowledgement of HIPAA Guidelines**

By signing this form, you understand the Notice of Privacy Practices of North Country Neurology, P.C. Our Notice of Privacy Practices provides information about how we may use & disclose your protected health information. We encourage you to read it in full and it is available in our office upon request. If we change our notice, you will be notified. I am aware of the notice of Privacy Practices of North Country Neurology, P.C.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (patient / parent / conservator / guardian)

Atrial Fibrillation Yes/No

Carotid stenosis Yes/No

Neck Surgery Yes/No

Back Surgery Yes/No

GERD (Reflux) Yes/No

Gastric Bypass Yes/No

Vitamin D deficiency Yes/No

Sleep disorder Yes/No

Depression Yes/No

Anxiety Yes/No

Bipolar disorder Yes/No



**PAST MEDICAL HISTORY: (Please circle YES or NO)**

Hypertension Yes/No

Diabetes Yes/No

High Cholesterol Yes/No

Heart Disease Yes/No

Strokes/TIA Yes/No

Seizures Yes/No

Migraines Yes/No

Other Headaches Yes/No

Thyroid Disease Yes/No

Anemia Yes/No

B12 deficiency Yes/No

**PAST SURGICAL HISTORY with DATES:**

**FAMILY HISTORY: List all medical conditions Living/Deceased)**

**Mother:**

**Father:**

**Siblings:**

**Children:**

**REVIEW OF SYSTEMS: (Please circle whichever applies)**

**Cardiovascular:** Chest pain/Pressure Palpitations Murmur lower leg edema

**Respiratory:** Shortness of breath Cough/Phlegm/Blood/Wheezing Smoking

**Gastrointestinal:** Nausea/Vomiting Diarrhea/Constipation Blood in stool Reflux

**Genitourinary:** Incontinence /Retention Frequency/Urgency Kidney stones

**Endocrine:** Weight loss/gain Heat/Cold Intolerance High blood sugar

**Infectious:** Fever Cough Diarrhea Burning on urination Night sweats

**Ear/Nose/Throat:** Ringing of ears Hearing loss Sinus pain/discharge

**Skin/Joint:** Rash Itching Hair/Nail changes Joint pain Joint swelling Trauma

**Psychiatric/Sleep:** Depression/Anxiety/Insomnia/Snoring /Apnea Restless legs Day time fatigue/sleepiness Morning headaches

**Neurologic:** Headaches Seizures, Memory loss Confusion Tremor Speech dysfunction Blurred/double vision Dizziness Neck pain Back pain Numbness/Weakness in limbs