SPECTRUM
NEUROLOGY CENTER

New Patient Information

Date: _____

Name: _____ Date of Birth: _____
Last First Middle

Address: _____
Street City State Zip Code

Work Phone: _____ Home Phone: _____ Cell Phone: _____

SSN: _____ Drivers License #: _____ Email: _____

❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated

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Employer: _____ Occupation: _____

Address: _____
Street City State Zip Code

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Address: _____
Street City State Zip Code

Medical Insurance Provider: _____

Group / Policy #: _____ Provider Phone #: _____

Address: _____
Street City State Zip Code

I realize this may not represent the full payment and I will be responsible for the balance due. A photo static copy of this authorization will be used as the original.

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1. **Is this medical visit due to a motor vehicle accident or fall with a possible or pending personal injury case that involves an attorney?** ❑ **Yes** ❑ **No**

   Attorney: _____ Phone #: _____

2. **Is this medical visit due to an injury that occurred while on the job with a possible or pending workmen's compensation case?** ❑ **Yes** ❑ **No**

   Industrial Carrier: _____ Phone #: _____

   Address: _____
   Street City State Zip Code

   Work. Comp. Attorney: _____ Phone #: _____

If you answered YES to either question 1 or 2, please complete the remainder of this page.

If you answered NO to both questions 1 and 2, please mark an N/A on the page and proceed to page 3.

Please provide us with the details of your accident / injury:

Date of accident / injury: _____

What kind of accident was it (car, truck, work related etc.): _____

_____

How did the accident / injury occur? _____

_____

Did you go to the emergency room? ❑ Yes ❑ No

What tests have you had? (MRI, CT scan, X-ray, Blood tests) _____

_____

Have you seen any other doctor or therapists; if so please list their names: _____

_____

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Patient Health Information

1. Please list any other family member or friends, if any, other than the emergency contact person, who we may inform about your medical condition and diagnosis if needed. This includes treatment, payment and healthcare operations:

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

2. Please print the address of where you would like your billing statements and correspondence from our office to be sent, if other than your home address:
3.

   Address: _____
   Street City State Zip Code

4. Please print the telephone number where you want to receive calls about your appointment, if other than your home phone number. Please be aware that a cell phone is not a secure line or a private one. If interested in correspondence via email, please list.

   Phone #: _____ Email: _____

5. Can a confidential message (ie appointment reminders) be left on your voicemail: ❑ Yes ❑ No

Please notify the clinic of any changes in information (ie address / phone) as soon as possible

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

I acknowledge that I have read this notice and may be provided a copy upon request.

Patient Name (print): _____

Patient Name (signature): _____

Date: _____

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Release of Benefits

I hereby instruct (insurance carrier): _____

To Pay: Spectrum Neurology Center, LLC
3409 Division St.
Metairie, Louisiana 70002

1. I instruct the expense benefits allowable and payable to me under my current insurance policy as payment to the total charges for professional services paid directly to Spectrum Neurology Center. The payment will not exceed my indebtedness to the above mentioned assignee.

2. I have agreed to pay, in the current manner, any balance of said professional service charges over and above the insurance payment.

3. I understand that if insurance benefits are denied for any reason, I am responsible in full for the charges incurred at this facility.

I authorize Spectrum Neurology Center to release any information pertinent to my file to any insurance company, adjustor, attorney involved in this case, and hereby release Spectrum Neurology Center of any consequence thereof.

Patient Signature: _____

Date: _____

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NEUROLOGY CENTER

3409 Division St. Metairie, LA 70002 Phone: 504-454-7246 Fax: 504-454-3299

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: **Spectrum Neurology Center**

Address: 3409 Division St.

City: Metairie State: LA Zip Code: 70002

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

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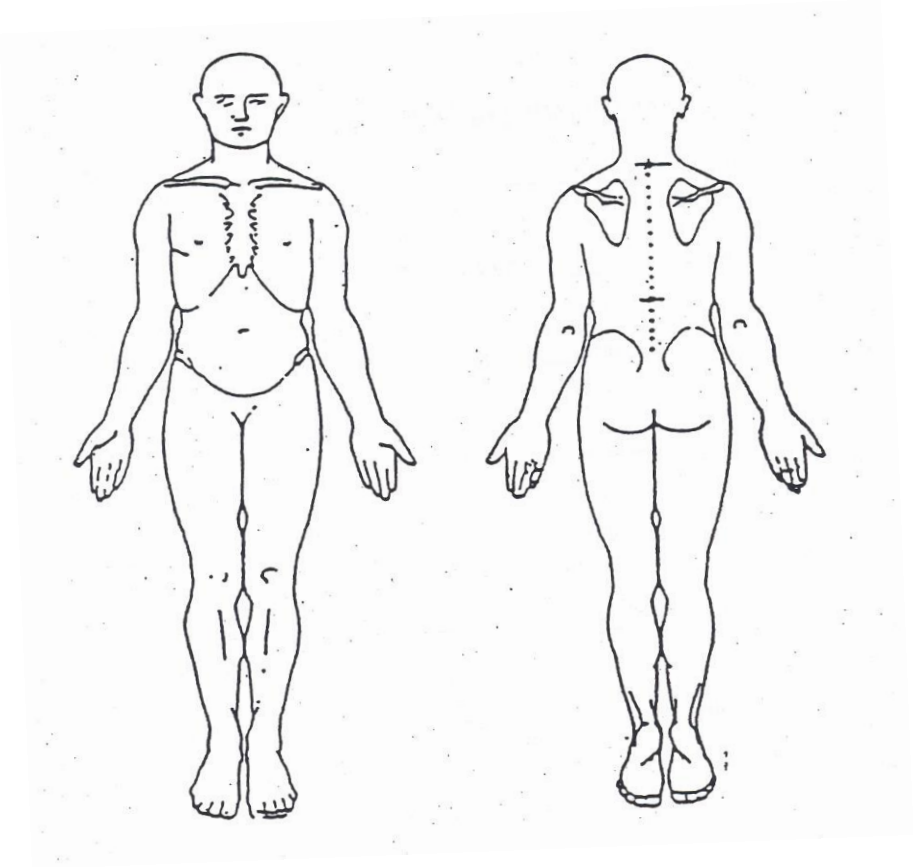
Patient Medical Information

Name (Print): _____ Date: _____

Reason for visit: _____ Referring Physician: _____

Pain Diagram: (Shade specific areas of pain, if applicable)



Pain Score: (Circle Number)

No Pain					Severe Pain					Hospital worthy Extreme Pain
0	1	2	3	4	5	6	7	8	9	10

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Past Medical History: (List any condition which you are taking medications for now or have had in the past)

_____ _____

_____ _____

_____ _____

Past Surgical History: (List all surgeries especially any surgery of the spine, if applicable)

_____ _____

_____ _____

_____ _____

Medications:

_____ _____

_____ _____

_____ _____

_____ _____

Family History: (cancer, Diabetes, heart disease, etc)

_____ _____

_____ _____

Social History:

Tobacco Use: ❑ Yes ❑ No; if yes, packs per day _____ and years of use _____

Alcohol Use: ❑ Yes ❑ No; if yes, amount per week _____

Illicit Substance used in the past: ❑ Yes ❑ No; if yes, type and amount _____

Work Status: Are you ❑ employed ❑ unemployed ❑ disabled ❑ retired

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Allergies: ❑ No known drug allergies

_____ _____

_____ _____

Review of Symptoms: (Please check all that apply)

Neurological / Psychiatric
- ☐ Headaches
- ☐ Fainting
- ☐ Convulsion
- ☐ Paralysis
- ☐ Speech Problems
- ☐ Memory Problems
- ☐ Hallucinations
- ☐ Tremors
- ☐ Sleep Disturbances
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Sleep
- ☐ Psychiatric treatments

Musculo-Skeletal
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Cramps
- ☐ Muscle Weakness

Skin
- ☐ Rashes
- ☐ Changes in skin color
- ☐ Bruising

Constitutional
- ☐ Weight gain / Loss
- ☐ Fever
- ☐ Chills
- ☐ Tiredness / fatigue
- ☐ Weakness

Cardiovascular
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Poor Circulation
- ☐ Irregular Heart beat
- ☐ Swelling of ankles / legs
- ☐ Low blood pressure

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough
- ☐ Wheezing
- ☐ Cough of blood

Genito-Urinary
- ☐ Blood in urine
- ☐ Excessive urination
- ☐ Difficulty in urinating

Endocrine
- ☐ Diabetes
- ☐ Low Sugar
- ☐ Hypo / Hyper Thyroid

Gastro-Intestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Bloating

Eyes / Ears / Nose / Throat
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye pain
- ☐ Loss of vision
- ☐ Earache
- ☐ Nosebleed
- ☐ Ringing in Ears / Tinnitus
- ☐ Hoarseness

Signature: _____ Date: _____