

 **CENTER FOR
Neuroscience**
NEUROLOGY • PSYCHOLOGY • NEUROPSYCHOLOGY

Patient Information:

Today's Date: _____

Name: _____

Date of Birth: _____

Social Security Number: _____

Marital Status: _____ Gender: _____

Street Address: _____

City/ State / Zip Code: _____

Phone # _____ Cell # _____

E-mail Address: _____

Which of the following **languages** can you speak and/or understand? Please circle:

English Spanish Creole French Portuguese Hindi/Urdu other _____

Ethnicity: Non- Hispanic/Latino _____ **Race** (circle) Caucasian African-American Hispanic
Hispanic/Latino _____ Indian Oriental Other _____

Employer: _____

Employer Phone No.: _____

Emergency Contact: _____

Contact Phone No.: _____

Name of Caregiver / Guardian: _____ Phone No.: _____

Purpose of Visit (please circle): Neurological Evaluation Diagnostics

Physical Rehabilitation Neuropsychological Evaluation/ Psychological Therapy

Insurance Information:

Name of Insurance Company: _____

Policy and or Claim Number: _____

Date of Accident or Injury (if applicable): _____ Auto Accident or Worker Compensation

If your visit is accident or injury related, have you done the following?

Do you have an attorney? Yes No

Name of your attorney: _____

Patient's Signature

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HISTORY OF PRESENT ILLNESS:

Please describe your main problem or reason for making an appointment _____

When did symptoms begin? _____ Have you been treated for this problem before? Yes No

If yes, please describe the treatment you received including dates:

PAST MEDICAL HISTORY

PROBLEM / DATE

PAST SURGICAL HISTORY (Please list)

SURGERY/YEAR

_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS:

List all medications you are currently taking: (include non-prescription and occasionally used medicines).

Current medication

Dosage/ Time taken

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all psychiatric medicines you have been prescribed in the past (including anti-depressants, anti-anxiety, anti-psychotics or medications used to help you sleep).

Medication Name

Dates

How long you took it

Side Effects

_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been hospitalized for a mental/ psychiatric illness? If so, please list dates and hospital:

ALLERGIES (List any medication, food or other allergies):

Do you have a pacemaker? Yes No

FAMILY HISTORY:

Please use the space below to list all of your immediate family (parents, siblings, and children).
Under illnesses, please list serious illnesses or diseases, especially psychiatric/mental illness.

<u>RELATIONSHIP</u>	<u>AGE</u>	<u>ILLNESS/ CAUSE OF DEATH</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILDREN:

_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Married _____ Divorced _____ Widowed _____

Number of Children _____

Birth state and where you were raised: _____

Education Level: High School Graduate _____ Some College _____ College Graduate _____

Degrees: _____

Employment Status: employed _____ Unemployed _____ Retired _____ Student _____

Smoking: Currently smoking _____ Former smoker _____ number of years: _____ Never smoked _____

Alcohol History: Never drinks _____ Currently drinks _____

Alcohol: approximate drinks per week: _____

Exercise: type: _____ frequency: _____

Hobbies, interests: _____

Are you currently driving? _____

Living Arrangements: With whom do you live? _____

- _____ Home
- _____ Assisted living
- _____ Nursing home

Is there any other information you want to make us aware of? _____

PAST MEDICAL/ FAMILY HISTORY

Please list any serious illness or ongoing medical problems since childhood. Include any surgical procedures:

Conditions	Self	Father	Mother	Siblings	G-parent	Other
Asthma						
High blood pressure						
Diabetes						
Heart disease						
Arrhythmia						
Cancer						
High cholesterol						
Stroke/ TIA						
COPD						
Chronic bronchitis						
Emphysema						
Seizures						
Dementia						
Alzheimer's disease						
Parkinson disease						
Huntington's disease						
Gastritis						
Ulcers						
Thyroid disease						
Liver disease/ Hepatitis						
HIV/ AIDS						
Sinusitis						
Kidney disease						
Head/ Brain injury						
STD						
Reflux Esophagitis						
Glaucoma						
Macular Degeneration						
Cataracts						
Headaches/ Migraine						
Miscarriages/ stillbirth						
Vertigo						
Tremors						
Multiple Sclerosis						
Birth/ Developmental Problems						
Hypoxia						
Depression						
Anxiety Disorder						
Schizophrenia						
Bipolar Disorder (Manic Depression)						
Obsessive Compulsive Disorder						
ADD/ADHD						
Learning Disability						
Post Traumatic Stress Disorder						
Other:						

REVIEW OF SYMPTOMS: Please check any of the following that pertain to you
Give dates, duration of symptoms and details when applicable.

CONSTITUTIONAL

- Lack of energy or fatigue _____
- Loss of appetite _____
- Difficulty sleeping _____
 - Awake early and can not return to sleep
 - Have trouble falling asleep

EYES

- Eye pain _____
- Blurred or double vision _____
- Sensitive to glare _____

EARS/NOSE/THROAT/NECK

- Problems with sense of smell _____
- Problems with taste _____
- Problems with hearing _____
- Uses hearing aid _____

CARDIOVASCULAR

- Chest pain _____
 - At rest _____
 - With activity _____
- Swollen ankles _____
- Palpitations or heart racing _____
- High blood pressure _____
- High cholesterol _____

RESPIRATORY:

- Cough _____
- Asthma or wheezing _____
- Become short of breath when walking or with activity _____

GASTROINTESTINAL:

- Problems swallowing _____
- Burning in chest or stomach after meals or when lying down _____
- Constipation _____
- Diarrhea _____
- Change in color of stool/ black or tarry stools? _____

GENITAL/ URINARY:

- Delayed ejaculation _____
- Difficulty holding in urine _____
- Difficulty maintaining an erection _____
- Difficulty urinating _____
- Frequent urinary tract infections _____
- Loss of interest in sex _____
- Need to urinate more frequently _____
- Pain when urinating _____
- Pain with intercourse _____
- Pain with intercourse _____

MUSCULOSKELETAL:

- Back pain _____
- Difficulty standing up from sitting _____
- Neck pain _____
- Other pain _____
- Pain greater in the morning and decreases with activity _____
- Stiffness or pain in joints _____

NEUROLOGICAL:

- Confusion _____
- Difficulty finding your way _____
- Difficulty maintaining home _____
- Difficulty managing finances _____
- Difficulty speaking _____
- Dizziness or fainting _____
- Feels dizzy when stands up _____
- Forgetfulness _____
- Head trauma _____
- Headaches or migraines _____
- Numbness or tingling in toes and fingers _____
- Problem with balance _____
- Recent fall or falls frequency _____
- Seizure or fits _____
- Sleep problems such as loud snoring, gasping for breath, morning headaches,
daytime sleepiness or leg jerking _____
- Tremor or difficulty writing _____

PSYCHIATRIC

- Anxious, restless ,or irritable _____
- Crying Spells _____
- Depression , persistent sadness or feeling blue _____
- Difficulty concentrating _____
- Feelings of hopelessness or worthlessness _____
- Hallucinations _____
- Hearing voices _____
- Loss of pleasure in life _____
- Paranoia _____
- Thoughts of hurting someone else _____
- Thoughts of suicide _____

ENDOCRINE:

- Cold intolerance _____
- Dry Skin _____
- Hair loss or coarse hair _____
- Heat intolerance _____
- Hoarse Voice _____
- Thyroid disease _____
- Weight gain or loss _____

ACTIVITIES OF DAILY LIVING

IF THERE ARE NO PROBLEMS WITH ACTIVITIES OF DAILY LIVING PLEASE SKIP TO PAGE 11

PLEASE DESCRIBE HOW MUCH HELP IF ANY YOU NEED WITH EACH OF THE FOLLOWING ACTIVITIES. CHECK THE MOST APPROPRIATE ANSWER BELOW:

EATING:

- Eat without assistance (plans meals, cooks, feeds self, cleans) _____
- Eat with minor assistance at meal times (e.g. preparing food) _____
- Eat with moderate assistance (e.g. planning and cooking) _____
- Need extensive assistance for all meals _____
- Cannot feed self at all _____

DRESSING:

- Dresses/ undresses and selects clothes without assistance _____
- Dresses/ undresses with minor assistance _____
- Needs moderate assistance in dressing or selection of clothes _____
- Needs major assistance in dressing _____
- Completely unable to dress and resists help _____

GROOMING: (combing hair, shaving)

- Always neatly dressed and well groomed without assistance _____
- Grooms adequately with occasional minor assistance _____
- Needs moderate and regular assistance or supervision _____
- Needs total grooming care but remains well-groomed after getting help _____
- Resists efforts to help maintain grooming _____

BATHING:

- Bathes in tub/shower or takes sponge bath without assistance _____
- Bathes self but needs help getting in and out of tub/shower _____
- Washes face/hands but cannot bathe rest of body _____
- Does not wash self but is cooperative with help _____
- Does not try to wash self and resists help _____

TOILETING:

- Cares for self at the toilet completely and no incontinence _____
- Needs reminders or help cleaning self or may have rare accidents _____
- Soils or wets clothes while asleep _____
- Soils or wets clothes while awake _____
- Has little or no control over bladder or bowels _____

WALKING:

- Walks around neighborhood or city alone _____
- Ambulates in home or within one block from home alone _____
- Ambulates well with assistance of another person, or alone using _____
- Railing, cane, walker, wheelchair _____
- Sits unsupported in chair or wheelchair, but can't ambulate without help _____
- Bedridden more than half the time _____

TRAVELING:

- Travel independently on public transport or drives own car _____
- Arranges own travel by taxi but does not use public transportation _____
- Travels using public transportation when assistance of another person _____

FINANCES:

Manages financial matters independently _____
Manages day-to-day purchases but needs help with banking _____
Or major purchases _____
Incapable of handling money _____
Does not apply _____

TELEPHONE:

Operates the telephone on own initiative _____
Dials only a few well know numbers _____
Answers telephone and takes messages but doesn't dial _____
Answers telephone but cannot take messages and does not dial _____
Does not apply _____

FOOD PREPERATION:

Plans, prepares, and serves adequate meals independently _____
Prepares adequate meals if supplied with ingredients _____
Heats and serves prepared meal or prepares simple meals but _____
Does not maintain an adequate diet _____
Needs to have meals prepared and served _____
Does not apply _____

HOUSEKEEPING:

Maintains own house alone or with occasional assistance _____
Performs only light daily tasks _____
Performs light daily tasks but cannot maintain an acceptable _____
Level of cleanliness _____
Does not participate in any housekeeping tasks _____
Does not apply _____

SHOPPING:

Takes care of all shopping needs independently _____
Shops independently for small purchases _____
Needs to be accompanied on any shopping trip _____
Completely unable to shop _____
Does not apply _____

MEDICATIONS:

Independently takes medication correctly _____
Takes responsibility for taking medications if prepared in _____
Advance in separate doses _____
Not capable of dispensing own medication _____
Does not apply _____

DRIVING:

Drives alone safely _____
Drives alone but has had one or more recent accidents _____
Drives alone but has gotten lost _____
Drives only with someone else in the car _____
No longer drives _____
Never drove/ does not apply _____

Authorization for Medical Records and Reports

Date: _____

To: _____

You, and any person associated with you, are hereby authorized to give to Center for Neuroscience or any representative thereof any and all information which may be requested regarding my physical condition and treatment rendered by you thereof, and if necessary to allow them, or any physician appointed by them, to examine and X-Ray pictures/ CT or MRI scans/ electro-diagnostics of me, or records which may have information regarding my condition or treatment.

Please Provide the Names and Phone Numbers of your physicians that you would like to have your records forwarded :

PRIMARY CARE _____

INTERNIST _____

CARDIOLOGIST _____

PODIATRIST _____

OTHER _____

Patient's Signature: _____

Print Name: _____

DOB: _____

SS #: _____

Witness' Signature: _____

Authorization for Release of Insurance Information

Date: _____

To: _____

You, and any person associated with you, are hereby authorized to give to The Center For NeuroScience or any representative thereof any and all information which may be requested regarding insurance claim information for your clients P.I.P. claim. Clients name in order to process any foregoing claims acquired by the patient.

Patient's Signature _____

Print Name: _____

DOB: _____

SS#: _____

Witness' Signature: _____

Conditions for Admission

Medical Consent: The undersigned consents to any X-Ray, examinations, and/or medical services rendered to the patient under the general and special instructions given by the physician.

Minors: If the patient is a minor or an incapacitated person, the undersigned hereby consents for any medical procedure on his/her behalf which the physician may consider necessary in the treatment of his/her care.

Liability: The patient is under the care of the Center for NeuroScience. Neither Dr. Siddiqui nor Dr. Joyce is liable for any act or omission in following the instructions given by Dr. Siddiqui or Dr. Joyce.

Personal Valuables: It is agreed and understood that the medical practice of the Center for NeuroScience shall not be liable for the loss of and/or damage to any personal property items (i.e. money, jewelry, dentures, documents, garments etc.).

Payment: The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, the Center for NeuroScience may disclose portions of patient's medical records, to any person or corporation which is or may be liable for all or any portion of the charges for services provided the Center for NeuroScience. **If your account is delinquent at 60 days, 25% collection fee, will be added to the amount due.**

Patient's Signature

Printed Name



Direction of Payment

I authorize the Center for NeuroScience to release any information acquired in the course of my examination to my insurance company. I hereby authorize payment directly to the Center for NeuroScience of the medical benefits, if any, otherwise payable to the provider for services not to exceed the provider's usual and customary fee. I also authorize the refund of over paid insurance benefits where my coverage is subject to a coordination of benefits. I recognize, understand and accept that I am financially responsible to the provider for all charges for any unpaid balance or fee not covered, In the event that I have no insurance or my insurance coverage is rejected. The undersigned agrees to pay all costs of collection, including a reasonable attorney's fee, and agrees to pay the legal rate of interest on the account until paid in full and hereby waive all rights of exemption under the constitution and the laws of the State of Florida.

I agree that the Center for NeuroScience be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor's bills when sent directly to their office.

I request that payment of authorized medical benefits be made on my behalf to the Center for NeuroScience for any services furnished to me by the physician or his employee. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits payable for related services.

Name of Insurance Company

Name of Insured

Insurance Claim / I.D. Number

Patient's Full Name Printed

Patient's Signature (Parent or legal guardian if patient is a minor)

Center for NeuroScience Policy Regarding No-Shows

It is the policy of Center for NeuroScience that patients who do not attend a scheduled appointment (or fail to cancel within one full business day prior to the scheduled appointment) will be charged a no-show fee of \$50.00 for each hour scheduled.

Patricia M. Joyce Ph.D.
Director, Center for NeuroScience

Samuel F. Siddiqui, MD, MPH
President, Center for NeuroScience

I agree to pay a no-show fee of \$50.00 for every scheduled hour with Dr Joyce and Dr. Siddiqui that I failed to attend or cancel within one full business day prior to the appointment. I give express permission to the Center for NeuroScience to charge my credit card, on file, for the appropriate amount.

Patient's Name (please print)

Signature

Date

E-Prescribing Consent Form

Patient's Name _____

Center for Neuroscience is in the process of implementing ePrescribing:

- ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011
- ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.
- ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

Patient Consent:

I agree that Center for Neuroscience may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. This consent form will be updated on an annual basis.

Please provide our office with your pharmacy name, address, phone number/ fax number

Pharmacy Name: _____

Address: _____

Ph# _____ - _____ - _____

Fax#: _____ - _____ - _____

_____/_____/20_____
(Patient Signature) Date

NOTICE of PRIVACY PRACTICES

I, _____ acknowledge that I have received the
Notice of Privacy Practices.

Signature: _____

Date: _____



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ASSIGNMENT OF BENEFITS

Claim No: _____

Adjuster: _____

The undersigned patient hereby assigns the benefits of insurance under the applicable automobile policy

to: Doctors' name: _____ at

the **Center For Neuroscience** for service rendered to the undersigned patient and covered by Personal Injury Protection (PIP) coverage under the policy issued to:

(Insured's' Name): _____

and in accordance with Florida Statute 627.736 (5)

The undersigned patient further agrees to pay any co-payment and/or deductible not covered by the aforementioned PIP coverage.

Patient Signature

Date

Print name here: _____

The undersigned hereby accepts assignments of insurance benefits for service rendered to:

(Patient's Name): _____
with such benefits to be paid directly to me under:

(Insured's Name): _____'s

Personal Injury Protection coverage with _____ and in

Accordance with Florida Statute 627.336(5)



Physician Signature

Date

Print Name here: _____