Neurology Associates of Norwalk, P.C. 637 West Avenue, Suite 200 Norwalk, Connecticut 06850

Patient name:_____ **Date of Birth:**_____

Race: African American/Asian/ Caucasian/Hispanic/ Native American/Pacific Islander **Ethnicity**: Hispanic or Latino/not Hispanic or Latino/Unreported

Preferred language: English or other:_____ **Gender: Male Female or Other:** _____

Address:_____ City:_____ State:_____ Zip:_____

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

Employer name:_____

Employer address:_____

Emergency contact name:_____Emergency#_____

Confidential Channel Communication Request

As required by the Health Insurance Affordability and Accountability Act of 1996, you have a right to request communication concerning personal health information be made through confidential channels. This medical practice will not ask why you are making a request, and we will make reasonable efforts to accommodate all reasonable requests. **Some method of contact must be provided.** We regret we are not currently using e-mail. We will routinely leave computerized appointment reminder phone calls if you allow us to contact you by phone.

I hereby request the use of confidential channels for communication of information related to my personal health, treatment or payment as follows: (indicate choice)

_____You may contact me by telephone at the above cell phone number / Home phone number/ work phone. You may leave a recorded message.

OR _____ You **may not** contact me by phone.

_____You may contact by mail: home address as above **or** other address as follows:

_____ _____City_____ State:_____Zip:_____

Patients often give us permission to discuss information with family or other individuals. If you want us to be able to talk to someone, we need to verify your permission. If you don't give permission for us to talk to anyone, leave it blank.

You may leave a message with the following person and/or discuss my personal medical information with the following person.

Name:_____ Relationship:_____

Phone#_____ Address:_____

✓ Patient signature:_____ Date:_____

Billing information: Each year, and with any change in your insurance coverage, we need to make a copy of your insurance card. Neurology Associates will be happy to submit claims to your insurance company. Your co-pay is payable at time of service, as this is a contract between your insurance company and you. You understand that you may be asked to reschedule your appointment if you're unable to make payment. People who are self-pay, or who have insurance that we do not participate in, must pay at the time of service. We accept VISA, Master card, checks, and cash. If your visit is related to a motor vehicle accident, you must supply Auto Carrier claim information or denial of Med Pay benefits. If your insurance company requires you to obtain a referral to see a specialist, you understand it is your responsibility to obtain this, and that if you do not have a current referral, you will be rescheduled.

There is a $35 service charge for missed appointments if less than 24 hours notice is given.

I authorize the release of information necessary to determine the liability for payment and to obtain reimbursement of any claim. The assigned will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original. I hereby authorize said assignee to release the benefits payable to which I am entitled, including Medicare, HM O's, private insurance and other health plans, to Neurology Associates of Norwalk, P.C. I agree the insurance information provided by me is true and correct. If this information is invalid, I agreed to be fully responsible for payment. If my insurance carrier requires a referral and I do not obtain one, I will be responsible for payment. I further agree that if my physician does not participate with my insurance, I will be responsible for payment.

✓ Patient signature:_____ Date:_____

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

Primary Care Physician:_____

Requesting Physician:_____

Explain the problem that prompted this visit to a neurologist::_____

Onset/duration:_____

What treatments have you had for this problem? _____

What tests have been done for this problem? _____Where?_____

Is the problem related to an auto accident? Yes or no If yes, date of accident:_____ Last day worked:_____

Is the problem work related? Yes or no If yes, date of accident:_____ Last day worked:_____

What is your height? _____ft_____inches. What is your weight? _____ lbs Are you: right-handed /left-handed / ambidextrous (both)

Medical problems: Please circle any medical problems you have had or currently have, or please list if you have a condition that is not included

Neurological: Migraines- Multiple Sclerosis - Neuropathy- Parkinson's disease - Seizures - Concussion - Stroke- TIA- intracerebral hemorrhage- memory problems

Neck pain - back pain – sciatica- learning disability other_____

Cardiovascular: High blood pressure - coronary artery disease- heart attack -atrial fibrillation- cardiac stent- bypass graft

Pacemaker – Defibrillator- peripheral vascular disease other_____

Respiratory: Asthma – COPD – emphysema - lung cancer other_____

Endocrine: Diabetes – hypothyroidism - hyperthyroidism other_____

Gastrointestinal: Ulcers - gastro esophageal reflux – hepatitis - colon cancer – other_____

Hematologic: Anemia – hemophilia - leukemia- lymphoma - hypercoagulable state other_____

Psychiatric: Anxiety –depression - bipolar disorder – ADHD - schizophrenia - substance abuse other_____

Musculoskeletal: Osteoarthritis - rheumatoid arthritis – osteoporosis - osteopenia other_____

Cancer : What type of cancer?_____ chemotherapy - radiation - cancer surgery

Eyes and ears: Cataract – glaucoma - vision loss- " lazy eye" double vision hearing loss other_____

Previous surgeries: Tonsils – appendix- hysterectomy- gallbladder - hernia other_____

Review of systems: Please circle any symptoms you have recently had

Fever – chills- recent visual change – cough - shortness of breath - chest pain- change in bowel or bladder habits- bleeding- joint pain- rash- headache

Other:_____

Social History:

Tobacco use: Never Quit at _____ age Currently smoke_____pack(s) per day

Alcohol use: Never Quit at _____age Currently drink_____ drinks per week or _____drinks per year.

Any Illicit drug use?: list_____

What is your occupation? Retired Student Homemaker On disability Employed as_____

What is your marital status? Single Married Divorced Widowed Domestic Partner

Neurology Associates of Norwalk , PC

List any allergies to medications, Latex or contrast dye. Please indicate the reaction, if known.

Medication or product	Reaction

Please give us a list of your current medications. Include over-the-counter medications, like aspirin, and supplements (continue on reverse if needed or attach a list)

Medication Name	Dose	When Taken

Family History: Are you adopted? Yes or No Please list medical problems in your family members, such as migraine, stroke, high blood pressure, heart disease, neuropathy, dementia, and type of cancer, if any. List cause of death , if known.

Mother:_____

Father:_____

Brothers and sisters:_____

Other family members:_____

Acknowledgment of Receipt of Privacy Practices

Patient Name:_____

I hereby acknowledge I received a copy of this medical practice's notice of privacy practices, including CT Social Security Act. I further acknowledge that I was informed that a copy of the current notice will be posted in the reception area and that I may request a copy of any amended notice of privacy at each appointment.

- ✓ Signature:_____ Date:_____

I authorize the viewing of external prescription history information. A prescription history contains prescription records provided by community pharmacies and pharmacy benefit managers.

- ✓ Signature_____ Date:_____

If the above not signed by the patient, please indicate your relationship to the patient::_____

Office use only:

Acknowledgment refused:_____

Reason for refusal_____

Form received by:_____