TALLAHASSEE NEUROLOGICAL CLINIC

NEW PATIENT INFORMATION

Tallahassee Neurological Clinic- Division of Pain Management

Name: _____ Birth Date: _____

Last First Middle

Social Security #: _____ Gender: ☐ Female ☐ Male

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Other of Undetermined

Preferred Language: _____ Race: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

How do you want to receive appointment reminders? ☐ Phone Call ☐ Text Message ☐ Email

Referring/Requesting Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Contact Person in case of emergency: _____

Relationship to contact: _____ Contact Phone: _____

Insurance Information

***** Please give all insurance cards to the receptionist at the front desk*****

Was this related to an accident? ☐ Yes ☐ No If yes, ☐ Auto ☐ Work ☐ Other _____

If this was related to an accident, Date of Injury _____

If this was related to an auto accident were you treated within 14 days of the accident: ☐ Yes ☐ No

If yes, where were you treated? _____

I have completed this form completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services. Assignment of Benefits: I authorize payment of Medical benefits to Tallahassee Neurological Clinic for services rendered by any physician of Tallahassee Neurological Clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

Signature of Patient or Responsible Party: _____ *Date:* _____

TALLAHASSEE NEUROLOGICAL CLINIC, P. A.

DIVISION OF PAIN MANAGEMENT
2824-1 MAHAN DRIVE
TALLAHASSEE, FLORIDA 32308
HISTORY INTAKE FORM

PLEASE ANSWER ALL QUESTIONS OR WRITE *N/A* IF THE QUESTION DOES NOT APPLY
If paperwork is not completed, your visit may be delayed

Name_____ Date_____
First MI Last
Date of Birth____/____/____Age_____ Sex: ( )Male ( )Female

Main Reason for Visit: (Please indicate *exactly* where your main pain is):

_____

_____

Do you have any pain radiating into your: ARMS: _____RT; ___LT ? LEGS: ___RT; ___LT?

When did your pain/problem first begin? Give year or exact date:_____

How did pain begin?

____Accident at work	____Motor Vehicle Accident	____Illness (Explain)
____Accident at home	____Following Surgery (Explain)	____No explanation

Have you had any accidents or injuries before or since this pain began that may have had an effect on your current condition? _____Yes _____No

ALLERGIES:

Are you allergic to any medications? _____Yes _____No
If so, which ones:_____
Are you allergic to any type of tape? ___Yes___No Are you allergic to soaps:_____Yes_____No

ARE YOU TAKING DAILY ASPIRIN, COUMADIN OR PLAVIX (blood thinners)?
_____YES _____NO

Have you had any of the following treatments for your pain:

____Pain Medication ____Epidural Injections ____Physical Therapy ____T.E.N.S.
____Surgery ____Chiropractor ____Trigger Point Injections

If Surgery, enter type of surgery and date; if epidural injection or physical therapy, specify date:

_____

_____

Did this help? _____Yes ____No If yes, how long?_____

Which of the following tests have you had to evaluate your pain problem in the past year?

TEST	DATE	FACILITY	Was this test for back or neck?
X-Ray	_____	_____	neck____back____other____
MRI Scan	_____	_____	neck____back____other____
	_____	_____	neck____back____other____
CT Scan	_____	_____	neck____back____other____
	_____	_____	neck____back____other____
Myelogram	_____	_____	neck____back____other____
Discogram	_____	_____	neck____back____other____
Bone Scan	_____	_____	neck____back____other____
EMG /NCV	_____	_____	neck____back____other____

SOCIAL HISTORY:

Are you presently working? ___Yes ____No
If yes: _____Full Time _____Part Time _____# of Hours per week
If no: _____Medical Leave_____Disabled_____Personal Choice_____Retired _____Unemployed

WORKMAN'S COMPENSATION (If applicable):

What type of work were you doing at time of injury?_____

_____

Date of injury:_____

If injured:

Is there a lawsuit? _____Yes _____No
Is the case settled? _____Yes _____No
Who is your attorney?_____
When did you last work at your usual job? _____

Patient Name _____ Date _____

CURRENT *PAIN* MEDICATIONS DOSAGE PRESCRIBED BY HOW TAKEN

(YOU MUST EITHER LIST ALL MEDS OR SUPPLY US WITH A LIST)

OTHER CURRENT *PRESCRIBED* MEDICATIONS

OTHER CURRENT *OVER THE COUNTER* MEDICATIONS/VITAMINS/MINERALS

TALLAHASSEE NEUROLOGICAL CLINIC
DIVISION OF PAIN MANAGEMENT
2824-1 MAHAN DRIVE
TALLAHASSEE, FL 32308
(850)558-1260
FAX: (850)558-1298

NEW PATIENT REVIEW OF SYSTEMS

DATE:_____

PATIENT NAME:_____**DOB:**_____

Please circle the **SPECIFIC** symptoms **IN EACH CATEGORY** below that pertain to you:

General—fever, chills, night sweats, weight loss,

Eyes—vision loss, blurry vision, light sensitivity

Gastro—nausea, abdominal pain, diarrhea, constipation

Urinary—painful urination, incontinence

Skeletal—back pain, neck pain, joint pain, muscle pain

Skin—rash, bruising, healing wound

Neuro—weakness, numbness, poor balance, headaches

Respiratory- shortness of breath, coughing, wheezing

Hematology- bleeding, abnormal bruising

Allergy- seasonal allergies, persistent infection

Psych—depression, anxiety, thoughts of violence/suicide

If none apply, please circle: **NONE**

Authorization & Assignment of Benefits, Medical Release Information, Privacy Statement

Patient's Name: _____ Date of Birth: _____

Emergency contact, Release of Medical Information,
Prescription pick up and Appointment Information

Tallahassee Neurological Clinic, P.A. has my permission to: discuss my **health information, including test results, schedule, confirm, cancel or reschedule my appointments, pick up prescriptions, samples, refills** with the individuals listed below.
If patient is under 18, parent(s) or legal guardian(s) must be listed on this form.

1) Name:_____ Relationship: _____

Phone No.: _____ ( ) Home ( )Work ( ) Cell

2) Name:_____ Relationship: _____

Phone No.: _____ ( ) Home ( )Work ( ) Cell

Privacy Statement

I acknowledge receipt of the Notice of Privacy Practices from Tallahassee Neurological Clinic, P.A. I understand that it is my responsibility to read the information provided therein.

Authorization and Assignment of Benefits

I authorized the release of any medical or other information necessary to process the insurance claim(s) for services rendered by Tallahassee Neurological Clinic, P.A. I request payment of government benefits, if applicable, to the party who accepts assignment. I authorize payment of medical benefits to Tallahassee Neurological Clinic, P.A. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered. Furthermore, I verify that all information provided by me on this document is accurate to the best of my knowledge at this time and that this information is good for one year from date of signature unless I request changes in writing.

Telephone Consumer Protection Act (TCPA)

I agree, in order to service my account or to collect monies I may owe, Tallahassee Neurological Clinic, P.A., and/or our agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. TNC and/or agents of TNC may also contact me by sending text messages or emails, using the email address I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that Tallahassee Neurological Clinic, P.A., its employee and/or agents may contact me/us as described above.

Signature: _____ Date: _____