1944 CORLIES AVENUE
SUITE 206
NEPTUNE, NJ 07753
P - (732) 774-8282
F - (732) 774-4407

PETER P. BARCAS, D.O.
ALAN D. DEUTSCH, D.O.
STEPHEN J. MARTINO, M.D.
PAUL M. KOSTOULAKOS, D.O.
MELISSA JOHNSON, APN
ELIZABETH DIAZ, APN.

BOARD CERTIFIED IN NEUROLOGY

OCEAN MEDICAL PARK
190 JACK MARTIN BLVD., BLDG B3
BRICK, N.J. 08724
P - (732) 785-1500
F - (732) 785-0116

Patient Initial Intake Form

Date: ____/____/_____ *Referring Doctor*_____

Patient Name: _____, _____ _____

Last *First* *MI*

*Age*_____ *Handedness* ☐ *R* ☐ *L DOB*_____*Height* _____*Weight*_____

Social Security # _____-____-_____ *Preferred Language*_____

Ethnicity: ☐ *Non Hispanic/Non Latino* ☐ *Hispanic/Latino* ☐ *Patient refuses to answer*

Race: ☐ *Caucasian* ☐ *African American* ☐ *Asian* ☐ *Alaskan or Native Hawaiian* ☐ *Other*

*Home Address:*_____

*City:*_____*State:*_____*Zip Code:*_____

*Home Phone:*____-_____-_____ *Business Phone:*_____-_____-_____

*Cell Phone:*_____-_____-_____ *Pharmacy Name*_____-_____-_____

*Pharmacy Address:*_____*Phone number:*_____-_____-_____

*Name of Spouse or Responsible Parent:*_____

*Spouse DOB*_____ *Social Security #*_____-_____-_____

*Employer:*_____ *Occupation:*_____

This visit is: ☐ *Work related* ☐ *Health related* ☐ *Auto Accident related*

*If Workman's Comp/Auto Please provide health care to copy and ID #*_____

*Insurance Company 1:*_____

*Policy Number:*_____ *Group Number:* _____

*Name of Spouse or Responsible Parent:*_____

*Insurance Company 2:*_____

*Policy Number:*_____ *Group Number:* _____

*Adjuster Name*_____*Phone Number:*_____

*Attorney Name*_____*Phone Number:*_____

ASSIGNMENT OF INSURANCE BENEFIT

I hereby authorize direct payment of surgical/medical benefits to Monmouth/Ocean Neurology for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance .

MEDICARE-MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original.

*Patient Name Printed:*_____

*Patient or Parent Signature:*_____

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Medical History

Please fill out information as best as possible.

***Problem List**: (problem to be treated by neurologist)*

_____

***Past Medical History:** (problems not related to Neurology)*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgical/Hospitalization History:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Allergy:_____	***Reaction:***_____
_____	_____
_____	_____
_____	_____

*Patient Name Printed:*_____
*Patient or Parent Signature:*_____

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Medications: *(Please list all medications prescribed currently taken along with strength and how it is taken.)*

(Medication)	*(Strength)*	*(How it's taken)*

Vitamins/OTC's:

Social History:

Smoke: ☐ *Yes* ☐ *No* ☐ *Quit smoking*
If yes, how many PPD? _____ *If you quit smoking, when was it?* _____
Marijuana use? ☐ *Yes* ☐ *No*
Drink Alcohol? ☐ *Yes* ☐ *No* *If yes, how much?*_____
Caffeine: ☐ *Yes* ☐ *No* *If yes, how much?*_____
Exercise: ☐ *Yes* ☐ *No* *If yes, how much?*_____
Living Will: ☐ *Yes* ☐ *No*
Marital Status: ☐ *Married* ☐ *Single* ☐ *Divorced* ☐ *Widowed*
Frequent Traveler ☐ *Yes* ☐ *No* *When:* _____*Where:* _____
Employer: _____*Occupation:*_____

*Patient Name Printed:*_____
*Patient or Parent Signature:*_____

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Family History: *(Please provide relationship, Health problems, & Status)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Review of Systems: *(Please check all that applies)*

- ☐ *Fever*
- ☐ *Weight Loss/ Gain*
- ☐ *Insomnia*
- ☐ *Appetite*
- ☐ *Itching*
- ☐ *Bruising easily*
- ☐ *Rash*
- ☐ *Voice change*
- ☐ *Nasal congestion*
- ☐ *Sore throat*
- ☐ *Dizziness*
- ☐ *Tinnitus*
- ☐ *Hearing loss*
- ☐ *Shortness of breath*
- ☐ *Cough*
- ☐ *Chest Pain*
- ☐ *Palpitations*
- ☐ *Constipation*
- ☐ *Diarrhea*
- ☐ *Abdominal pain*
- ☐ *Nausea / Vomiting*
- ☐ *Urinary urgency*
- ☐ *Urinary frequency*
- ☐ *Urine Incontinence*
- ☐ *Joint pain*
- ☐ *Neck pain*
- ☐ *Back Pain*
- ☐ *Knee pain*
- ☐ *Hip pain*
- ☐ *Other joint pain*
- ☐ *Headache*
- ☐ *Speech change*
- ☐ *Balance change*
- ☐ *Weakness*
- ☐ *Memory change*
- ☐ *Anxiety*
- ☐ *Depression*
- ☐ *Delusions*
- ☐ *Paranoia*

*Patient Name Printed:*_____

*Patient or Parent Signature:*_____