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

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BOARD CERTIFIED IN NEUROLOGY

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

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: X_____

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Medical History

Please fill out information as best as possible.

***Problem List**: (problems 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: X*_____

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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: X _____

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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: X*_____