1944 CORLIES AVENUE
SUITE 206
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BOARD CERTIFIED IN NEUROLOGY

OCEAN MEDICAL PARK
190 JACK MARTIN BLVD., BLDG B3
BRICK, N.J. 08724
P - (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-**

*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*

*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:_____***

_____ _____
_____ _____
_____ _____

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

*Patient Name Printed:*_____

*Patient or Parent Signature:*_____