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BOARD CERTIFIED IN NEUROLOGY

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

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_____*

*(Must have signature in order to share medical information with additional family members)*

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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:***

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

*Patient Name Printed*_____

*Patient or Parent Signature: X*_____

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## *Social History:*

*Smoke:* ☐ *Yes* ☐ *No* ☐ *Quit smoking*
*If yes how many PPD?* _____ *If you quit smoking when was it?* _____
*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:*_____

## *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:*

| | | |
|---|---|---|
| | | |
| | | |
| | | |

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

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***Allergies:***

*Allergy:*_____ *Reaction:*_____

_____ _____

_____ _____

_____ _____

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

| | | |
|---|---|---|
| ☐ ***Fever*** | ☐ ***Chest Pain*** | ☐ ***Back Pain*** |
| ☐ ***Weight Loss*** | ☐ ***Palpitation*** | ☐ ***Neck Pain*** |
| ☐ ***Weight Gain*** | ☐ ***Dizziness*** | ☐ ***Arthralgia*** |
| ☐ ***Sore Throat*** | ☐ ***Rash*** | ☐ ***Abdominal Pain*** |
| ☐ ***Ear Discomfort*** | ☐ ***Headache*** | ☐ ***Nausea/Vomiting*** |
| ☐ ***Nasal Congestion*** | ☐ ***Visual changes*** | ☐ ***Diarrhea*** |
| ☐ ***Cough*** | ☐ ***Change in Urination*** | ☐ ***Constipation*** |
| ☐ ***Shortness of Breath*** | ☐ ***Knee Pain*** | ☐ ***Hip Pain*** |
| ☐ ***Shoulder Pain*** | ☐ ***Elbow Pain*** | ☐ ***Arm Pain*** |
| ☐ ***Ankle Pain*** | ☐ ***Calf Pain*** | ☐ ***Depression*** |
| ☐ ***Thigh Pain*** | ☐ ***Easy Bruising*** | ☐ ***Hemotological disorder*** |
| ☐ ***Anxiety*** | ☐ ***Urinary Incontinence*** | ☐ ***Bowel Incontinence*** |
| ☐ ***Extremity Weakness*** | ☐ ***Wear Glasses*** | ☐ ***Wear Hearing aid*** |

*Patient Name Printed*_____

*Patient or Parent Signature: X*_____