



PATIENT DEMOGRAPHICS

First Name:		MI	Last Name:		Preferred Name:
Date of Birth:	Sex:	SSN:		E-Mail Address:	
Address:			City:	State:	Zip:
Home Phone:	Cell Phone:		Work Phone:	Employer:	
Preferred Phone Number:	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work	Marital Status:	Race/Ethnicity:
Ok to leave detailed message:	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work		
Referring Physician:			Primary Care Physician:		

Please provide first **and** last name. If they are not a local doctor, please provide phone and fax

IN CASE OF EMERGENCY

Name:	Address:	Relationship:	Phone
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Can we share medical information with your emergency contact? YES NO

PRIVACY

WHO CAN WE SHARE YOUR MEDICAL INFORMATION WITH? (Family members, etc. - Please give **full names**.
 (Please provide a contact phone number if they are different than your emergency contact above)

Please provide documentation if Power of Attorney applies

PHARMACY

Name:	Address (or major cross streets and city)	Phone no:
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PATIENT RESPONSIBILITIES

- I hereby authorize assignment of benefits to be paid directly to Amelia Barrett MD, Daniel Kitei D.O., Katie Coerver M.D.,PhD, Ro Elgavish M.D., PhD, Melissa Butler, PA-C
- I understand that it is my sole responsibility to check with my insurance company regarding coverage & cost for any procedures and/or office visits. I am responsible for obtaining all referrals and insurance authorizations.
- I authorize Amelia Barrett MD, Daniel Kitei D.O., Katie Coerver M.D., PhD, Ro Elgavish M.D., PhD, Melissa Butler, PA-C to provide protected health information to my insurance company for billing purposes.
- I understand that regardless of any insurance coverage or other potential co-guarantor or responsible party, I am accepting full financial responsibility for payment of all charges for services provided to me, my spouse, or dependents by this practice. The services provided include office visits, procedures (electromyography/nerve conduction studies or EMG/NCS, electroencephalogram or EEG, neurobehavioral testing and Botolium toxin or Botox injections) and online encounters via the patient portal. I agree that if my employer, insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges. I agree to pay a late fee of \$25 if my account should become over 60 days past due. In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 33% of the outstanding balance or a minimum of \$40.00 (whichever is greater) to offset in part the collection agency's fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.
- TCPA Acknowledgment - I authorize this office, its agents, and assignees to contact me by email, telephone, text/SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.
- A fee of \$50.00 may be assessed if I do not show up for a follow-up appointment or if I cancel non-testing appointments without 24 hours' notice. A fee of \$250 may be charged if I do not show up for a testing appointment. The implementation of this policy is at the discretion of the office and circumstances are always considered.
- I give permission for the office to access my external medication history.
- I acknowledge review of HIPAA notice and have received a copy if I requested it.
- I give consent to receive virtual check in services (including patient initiated online encounters via the patient portal)

 PATIENT or POWER OF ATTORNEY/GUARDIAN SIGNATURE

 DATE

If signed by a Legal Guardian or Power of Attorney

Legal Guardian/POA Name: _____ Relationship to patient: _____

*By providing your signature above, you attest that you have the legal right to sign for the patient.



NAME: _____

DATE OF BIRTH: ____/____/____

Which symptoms are you being seen for today? _____

Height: ____ft ____In	Weight: _____lbs
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*USE BACK OF PAGE IF NEEDED

MEDICATIONS, SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS*

Name	Strength (mg etc)	Frequency (how often?)	Condition this medication is for	Name	Strength (mg etc)	Frequency (how often?)	Condition this medication is for

Are you allergic to any medications? YES NO Is yes, which ones? _____

ADDITIONAL MEDICAL CONDITIONS*

MAJOR SURGERIES*

DATE (IF APPLICABLE)

FAMILY HISTORY

Father: Alive Deceased Unknown Medical Conditions: _____

Mother: Alive Deceased Unknown Medical Conditions: _____

Are there any other medical conditions that run in your family?

(Examples of medical conditions we are looking for: diabetes, hypertension, heart disease, stroke, mental illness, cancer etc.)

REVIEW OF SYSTEMS

(Please circle all that apply)

General: weight loss, weight gain, fevers **ENT:** sinus infections, ear pain/fullness, dizziness, ringing in ears
Eyes: blurry vision, double vision, loss of vision **Psychiatric:** sadness/depression, anxiety, hallucinations
Respiratory: shortness of breath, wheezing, cough **Genitourinary:** frequent urination, impotence, painful urination
Cardiovascular: heart palpitations, passing out/blackouts, poor circulation **Skin:** rashes, birthmarks, skin growths
Gastrointestinal: burning in stomach, constipation, diarrhea **Musculoskeletal:** weakness, joint pain, joint swelling
Neurologic: headache, difficulty swallowing, tingling/burning, neck/back pain, slurred speech, tremors, memory problems, balance problems, muscle cramps, numbness

ADDITIONAL QUESTIONS

SOCIAL HISTORY

(Please circle)

Do you have an Advanced Directive? YES NO
 If yes, have you assigned a decision maker? YES NO
 Have you received a flu shot? YES NO MM/YY: _____
 Have you received the pneumonia shot? YES NO MM/YY: _____
 Have you fallen in the past year? YES NO
 If yes, how many times did you fall? _____
 Did you need medical treatment? YES NO
 Is your appointment today regarding a work or auto related injury? YES NO
 WORK or AUTO What was the date of Injury? _____

Are you a:
 Current smoker
 If so, how much? _____
 Date started: _____
 Former smoker
 If so, date range: _____ - _____
 Never smoker

Do you drink alcohol?
 Yes
 If so, how often? _____
 No