NEUROLOGICAL INSTITUTE OF MICHIGAN
PATIENT INFORMATION FORM

PATIENT NAME: _____ **BIRTH DATE:** _____

HOME ADDRESS: _____ **SSN#:** _____

_____ **CELL:** _____

HOME TELEPHONE: _____ **WORK:** _____

EMPLOYER: _____

EMERGENCY CONTACT: _____

REFERRING DOCTOR: _____

PRIMARY CARE MD: _____ **PHONE:** _____

OFFICE ADDRESS: _____

RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT: _____ **PHONE:** _____

ADDRESS: _____ **BIRTH DATE:** _____

_____ **SSN#:** _____

EMPLOYER: _____

INSURANCE INFORMATION
PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS AND PICTURE IDENTIFICATION TO PHOTOCOPY

PRIMARY PLAN: _____ **COPAY:** _____

SUBSCRIBER: _____ **PLAN ID:** _____

SUBSCRIBER DOB: _____ **GROUP:** _____

SECONDARY PLAN: _____ **COPAY:** _____

SUBSCRIBER: _____ **PLAN ID:** _____

SUBSCRIBER DOB: _____ **GROUP:** _____

All professional services rendered are charged to the patient. If arrangements have been made to file your insurance, please be aware that the responsible party is responsible for all copayments, coinsurance, deductibles, and denied claims. Submission of a claim to the insurance company is strictly a courtesy performed by this office and does not guarantee payment of the claim.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY **DATE**

NAME: _____ *BIRTHDATE:* _____

PAST MEDICAL HISTORY

GENDER: ☐ **M** ☐ **F** **AGE:**_____ **HEIGHT:**_____ **WEIGHT:**_____

ALLERGIES: (PLEASE INCLUDE ALLERGIES TO MEDICATIONS, FOOD, SHELL FISH, LATEX, ETC.)

_____ _____ _____

_____ _____ _____

MEDICATIONS: (PLEASE LIST ALL CURRENT PRESCRIPTION & OVER THE COUNTER MEDICATIONS, INCLUDE NAME, DOSE, AND HOW YOU TAKE THE MEDICATION. INCLUDE VITAMINS, BIRTH CONTROL, AND HORMONES. NOTE: USE BACK OF THIS FORM IF NECESSARY)

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL CONDITIONS: (LIST ALL PROBLEMS FOR WHICH YOU HAVE BEEN TREATED)

_____ _____ _____

_____ _____ _____

_____ _____ _____

SURGERIES: (LIST ANY SURGERY & GIVE APPROXIMATE MONTH/YEAR OF SURGERY)

_____ _____ _____

_____ _____ _____

HAVE YOU HAD AN MRI OR SCAN? (PLEASE INFORM WHEN, WHO PERFORMED, & RESULTS)

HAVE YOU HAD AN EMG/NCV OR "NERVE TEST?" (PLEASE INFORM WHEN, WHO PERFORMED, & RESULTS)

HAVE YOU HAD A BLOOD TRANSFUSION WITHIN THE PAST 90 DAYS? YES NO

SOCIAL HISTORY:

DO YOU USE TOBACCO?	YES	NO	QUANTITY: _____HOW LONG: _____
DO YOU DRINK ALCOHOL?	YES	NO	QUANTITY: _____HOW OFTEN: _____
DO YOU USE CAFFIENE?	YES	NO	QUANTITY: _____HOW OFTEN: _____
DO YOU USE RECREATIONAL DRUGS?	YES	NO	LIST: _____

NAME: _____ *BIRTHDATE:* _____

FAMILY MEDICAL HISTORY:

(PLEASE X. FAMILY INCLUDES GRANDPARENT, AUNT & UNCLE)

FATHER'S FAMILY	*ILLNESS*	*MOTHER'S FAMILY*
_____	**ADDICTIONS**	_____
_____	**ANEMIA**	_____
_____	**ARTHRITIS**	_____
_____	**ASTHMA/LUNG DISEASE**	_____
_____	**BIRTH DEFECTS**	_____
_____	**BLEEDING DISORDER**	_____
_____	**CANCER (TYPE)**	_____
_____	**DIABETES**	_____
_____	**EPILEPSY**	_____
_____	**HEART DISEASE**	_____
_____	**HIGH BLOOD PRESSURE**	_____
_____	**KIDNEY DISEASE**	_____
_____	**MENTAL RETARDATION**	_____
_____	**PSYCHIATRIC DISORDER**	_____
_____	**STOMACH/BOWEL PROBLEM**	_____
_____	**STROKE**	_____
_____	**THYROID PROBLEM**	_____

OTHER: _____

REVIEW OF SYMPTOMS:

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING SYMPTOMS? PLEASE CIRCLE AND GIVE A BRIEF EXPLANATION.

CONSTITUTIONAL	**RESPIRATORY**	**NEUROLOGICAL**	**EYES**
FEVER	SHORTNESS OF BREATH	BLACKOUTS	VISION CHANGES
WEIGHT LOSS	SPUTUM PRODUCTION	SEIZURES	BLINDNESS BLIND SPOTS
WEIGHT GAIN	BLOOD IN SPUTUM	DIZZINESS	BLURRY VISION
FATIGUE/WEAKNESS	COUGH WHEEZING	TREMORS	DROOPY EYE

NAME: _____ *BIRTHDATE:* _____

GASTROINTESTINAL	**MUSCULOSKELETAL**	**PSYCHIATRIC**	**SKIN**
DIARRHEA	DIFFICULTY WALKING	DEPRESSION	RASH
BLOOD IN STOOL	PAIN IN LIMBS	ANXIETY	BLISTERS
CONSTIPATION	WEAKNESS	HALLUCINATIONS	ITCHING/SCALING SKIN
ABDOMINAL CRAMPS	NUMBNESS	STRESS	CHANGE IN MOLE
LOSS OF BOWEL CONTROL	MUSCLE JOINT PAIN	SUICIDAL THOUGHTS	BREAST LESIONS/LUMPS
EARS,NOSE,THOAT,MOUTH	**CARDIOVASCULAR**	**GENTIURINARY**	**HEMATOLOGIC**
SPEECH DIFFICULTY	SLOW/RAPID HEART RATE	PAIN IN URINATION	SWELLING EXTREMITIES
RINGING IN EARS	PALPITATIONS	URINARY DRIBBLING	“FREE” BLEEDING
SMELL OR TASTE	SKIPPED HEART BEATS	INABILITY TO URINATE	EASY BLEEDING
HEARING DEFICIT (LEFT, RIGHT)	CHEST PAINS/DISCOMFORT	BLOOD IN URINE	EASY BRUISING
ALLERGY	**ENDOCRINE**	**SLEEP**	
SEASONAL ALLERGIES	INTOLERANCE TO HOT OR COLD	DIFFICULTY FALLING ASLEEP	
WATERY ITCHY EYES	FREQUENT URINATION AT NIGHT	SNORING	
	INCREASED THIRST/APPETITE	RESTLESS LEG	
		STOP BREATHING IN SLEEP	

COGNITIVE MEMORY

I have noticed a recent decline in my memory.	YES	NO
Others (my friends or family) tell me that I am forgetting things they tell me.	YES	NO
My ability to concentrate seems to have declined recently.	YES	NO
I have suffered recent losses that might hurt some of my thinking abilities.	YES	NO
I get confused or easily distracted more than I used to.	YES	NO

BRIEF EXPLANATION: (USE BACK OF FORM IF NECESSARY)

MAIN REASON FOR YOUR VISIT TODAY:

NEUROLOGICAL INSTITUTE OF MICHIGAN

ACKNOWLEDGEMENTS & AUTHORIZATIONS

Acknowledgement of Review of Notice of Privacy Practices

I acknowledge a copy of the provider's Notice of Privacy Practices was made available to me at the location healthcare services were rendered. The Notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy of the Notice of Privacy Practices was made available to me to keep. If I came for health care services in an emergency treatment situation, I was able to view the Notice of Privacy Practices as soon as practicable after the emergency treatment was rendered. I have reviewed this office's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

X _____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

Insurance Legal Assignment of Benefits

I hereby authorize my physician to give my insurance company all information concerning every condition for which I have been under observation or treatment, the history obtained, physical and laboratory findings, diagnosis and treatment. I authorize payment of medical benefits to the physician for services rendered.

X _____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

Insurance Benefit Notification/Acknowledgement

I hereby authorize the physician to administer in the office such procedures, medications, and treatment which is considered therapeutically necessary on the basis of the findings in my case. I understand that a claim will be filed to my insurance carrier, worker compensation carrier, and/or personal injury carrier as a courtesy by this office. I understand that I am ultimately responsible for payment of services rendered regardless of the payment outcome of my insurance claim/claims.

X _____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

Medicare Assignment of Benefits

I authorize payment to be made to the physician. I authorize any holder of medical information about me to release to my insurance carrier or WPS and its agents and/or my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

X _____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**