LOCATION: ____________________PHYSICIAN:_____________________ACCT. NO.______________

Patient Name: ____________________________DOB:_____________ Telephone (_____) _________________

Address: ______________________________City_______________________State________Zip_______________

Marital Status: Single Married Divorced Widowed Sex: ________ Race: ___________________

Social Security #____

Employer Information

Company: ___________________________________ Position: ______________________

Address: ____________________________City_______________State:_____Zip:________Phone:_________

Spouse Information

Name: ___________________________DOB:____________________SS#________________________________

Employer: ____

Address: _____________________City_____________State:____Zip:_________Phone:______________

Spouse INS Co: _________________________________ Policy #:___________________Group #:_____________

Address: ____Phone:__________________________

In case of emergency contact: _______________________ Relationship: ______________ Phone #____________

GUARANTOR NAME IF NOT PATIENT: ____

REFERRED BY:

Name__________________________Upin#______________Address:____________________Phone:____________

INSURANCE: (PLEASE PRESENT CURRENT INSURANCE/MEDICAL CARD TO RECEPTIONIST)

Primary INS Co: ________________________________ Policy#:_______________ Group#:__________

Claims Address: ____Phone:_________________

Insured's Name____ Relationship to Pt: ________________

Employer: ____

Comments/Referral #:____

Secondary INS Co: _______________________________ Policy#:_________________Group #:________

Claims Address: ____ Phone: _________________

Insured's Name____Relationship to Pt: _________

Employer: ____

Comments/Referral #:____

Is this visit due to an employment-related or auto accident? Yes No

Date of Injury? ____________________ If yes, Nature and Location of Accident? __________________

____

____

PERMISION FOR TREATMENT: Permission is hereby granted to WEST TENNESSEE NEUROLOGY, P.C. to render such medical treatment as is deemed necessary.

RELEASE OF INFORMATION: To the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement, West Tennessee Neurology, P.C. may disclose portions of the patient's medical record and account to any person or corporation which is or may be liable for all or any portion of the patient's charges including but not limited to insurance companies, health care service plans or workers compensation carriers. The patient's medical record may also be released to the referring physician to ensure continuity of medical care.

FINANCIAL AGREEMENT: In consideration of the services rendered to the patient, the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of the facility. Should the account be referred for collections, the undersigned shall pay reasonable attorney's fees and collection benefits. I am responsible for the charges if I do not have an approved referral.

ASSIGNMENT OF INSURANCE BENEFITS: I request my insurance carrier to pay to West Tennessee Neurology, P.C. or the individual physician all benefits due me related to my pending claim for medical and surgical services.

MEDICARE B AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of this physician, any request payment of medical insurance benefits to the party who accepts assignment.

I have read and approved all of the above except for those items I have personally lined through and initialed.

Signature of Insured/Guardian/Patient ____

Date __________________________

Patient Name: ____ Date: _______________

1. Please describe your medical problem: ____

____

2. Please list and describe your past medical illness: ____

____

Have you had any of these? Please Circle.

A. High blood pressure
B. Heart Disease
C. Cancer
D. Diabetes Mellitus (sugar diabetes)
E. Stroke
F. Epilepsy
G. Mental Illness
H. Other____________

3. Have you had any operations? Please List.

_______________________ ___________________________ ___________________

_______________________ ___________________________ ___________________

_______________________ ___________________________ ___________________

4. Please list any medications you are taking:

_______________________ ___________________________ ___________________

_______________________ ___________________________ ___________________

_______________________ ___________________________ ___________________

5. Please list medication allergies:

_______________________ ___________________________ ___________________

_______________________ ___________________________ ___________________

_______________________ ___________________________ ___________________

6. Family History:

Father's age________ illness_______________ cause of death_________________

Mother's age_______ illness________________ cause of death_______________

Brothers____

Sisters____

7. Has anybody in your immediate family ever had? Please Circle.

A. High blood pressure
B. Heart disease
C. Cancer
D. Diabetes
E. Stroke
F. Mental illness
G. Epilepsy
H. Migraine

8. Weight history:
Present weight____________ Usual weight ________________

Any major changes in weight? How much_______ How many meals do you eat a day? ________

9. Habit History:

A. Smoking

1. Cigarettes # per day_______ How long________ Date started________
2. Cigar # per day________ How long________ Date started________
3. Pipe # per day_________ How long________ Date started________

B. Alcohol: Never ______ Occasional ______Moderate ______Heavy_________

C. Coffee: Cups per day: ________