# PATIENT INFORMATION SHEET

Name: _____ Social Security #: _____

Date of BIrth: _____ Sex (circle one): Male Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____ Cell Phone # _____

Pharmacy Name & Location _____

May we text you for appointment reminders? Yes _____ No _____

Do you want access to the patient portal? Yes _____ No _____

Email Address for Patient Portal: _____

Employment Status: Full-Time _____ Part-Time ____ Unemployed ____ Retired ____ Student ____

Name of Employer: _____ Work Phone: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Race Origin: African American ____ Asian ____ Caucasian ____ Hispanic ____ Other Race ____

## INSURANCE INFORMATION

Primary Insurance: Self _____ Spouse _____ Parent _____

Name of Insurance Company: _____

Policy #: _____ Group #: _____

***If this policy is under your spouse/parent please fill out this section below with their information***

Spouse/Parent Name: _____ Date of Birth: _____

Social Security #: _____ Place of Employment: _____

Secondary Insurance: Self _____ Spouse _____ Parent _____

Name of Insurance Company: _____

Policy # _____ Group # _____

## EMERGENCY CONTACT

Contact Name: _____ Phone # _____ Relationship: _____

Signature: _____ Date: _____

**Please Print & Bring to Office for your appointment.**

# PRIVACY INFORMATION

This section must be completed to authorize Metrolina Neurological Associates, to release/discuss your health information with someone other than you (the patient). This release is good until you (the patient) make changes or cancels the authorization by informing us in writing.

**LIST PEOPLE BELOW THAT WE MAY CONTACT OR SPEAK WITH ON YOUR BEHALF.**

**(Example: Family member(s) or anyone directly participating in ongoing medical care)**

| Name | Phone / Fax | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

I, _____, have read and authorize Metrolina Neurological
(Patient Name and Date of Birth)
Associates to release my healthcare information to the above-listed people or organizations.

Signed: _____ Date: _____

## ACKNOWLEDGEMENT AND AUTHORIZATION

I have read and understand the HIPAA/Privacy Policy for Metrolina Neurological Associates.

Signed _____ Date: _____

## PATIENT FINANCIAL REPONSIBILITES:

- The patient is ultimately responsible for payment of treatment and care.
- If your insurance requires a referral to a specialist, it is **YOUR** responsibility to get the referral before your scheduled appointment or you will be responsible for the visit.
- We will bill your insurance for you; however, the patient is required to provide the correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, deductibles, and all other procedures or treatments not covered by your insurance plan.
- Co-pays are due at the time of service.
- Co-insurance, deductibles, and non-covered items are due 30 days from receipt of billing. If you are unable to pay within 30 days, we will be happy to set up a payment plan with you.

I have read and understood the Financial Policy for Metrolina Neurological Associates

Signed: _____ Date: _____

**Name:** _____ **Date of Birth:** _____

**Pharmacy:** _____ **Referring Doctor:** _____

**Reason for today's visit:** _____

**Height** ____**ft** _____**in** **Weight**_____ **lbs** **Are you currently pregnant?** **Yes** _____ **No** _____

**Are you right or left-handed?** **Right** ____ **Left** ____

**Medication Allergies:** _____

**CURRENT MEDICATION AND DOSES: Please list below.**

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

**PAST MEDICAL HISTORY: Please check any past conditions that apply:**

| | | |
|---|---|---|
| Headache/Migraine | Heart Disease | Genitourinary Disease |
| Epilepsy/Seizures | Hypertension | Menstrual/Sexual Dysfunction |
| Stroke / TIA | Murmur | Venereal Disease |
| Head Injury | Thyroid Disease | Peptic Ulcer Disease |
| Dementia | Anemia | Congestive Heart Failure |
| Neuropathy | Cancer | Other Endocrine |
| Cervical Spine Disease | Diabetes | Mumps |
| Spinal Cord Injury | COPD | Arrhythmias |
| Lumbar Spine Disease | High Cholesterol | Polio |
| Other Neuromuscular | Asthma | Bleeding Disorder |
| Myocardial Infarction | Peripheral Vascular Disease | Measles |
| Depression | Liver Disease/Hepatitis | Allergy/Hay Fever |
| Mental Illness | Rheumatic Fever | Exposures |
| Arthritis | Pneumonia | Kidney Disease |
| Other: | | |

**PAST SURGICAL HISTORY: Please list any past surgeries that you have had and the approximate dates.**

_____

_____

_____

**Name:** _____ **Date of Birth:** _____

**Review of Systems: Please circle the following issues you currently experience.**

**General:** Chills Fever Weight Gain Weight Loss

**HEENT:** Diplopia Eye Pain Visual Disturbances Ear Problems Nose Problems Sinusitis Throat Problems Slurred Speech

**Neck**: Neck Pain Neck Stiffness

**Respiratory**: Difficulty Breathing Sputum Production

**Cardiovascular**: Chest Pain Hypertension Shortness of Breath

**Gastrointestinal**: Abdominal Pain Difficulty Swallowing Nausea Vomiting

**Musculoskeletal**: Back Pain Joint Pain Muscle Weakness

**Neurological:** Black-Outs Bladder Symptoms Blurred Vision Bowel Symptoms Confusion Convulsions Difficulty with gait/walking Dizziness Double Vision Falling Headaches Hearing Loss Imbalance Memory Loss Muscle Cramping Muscle Twitching Numbness Pain Speech Disorder Syncope Tingling Tinnitus Vertigo Visual Loss Weakness

**Psychiatric:** Anxiety Depression Disorientation Hallucinations Inability to Concentrate Uncontrollable crying and/or laughing

**Endocrine**: Appetite Changes Heat/Cold Intolerance Thyroid Problems

**Hematology:** Easy Bruising Easy Bleeding Painful Lymph Nodes

---

**SOCIAL HISTORY:**

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____

Have you ever smoked? Yes ____ No ____
How many years have you smoked? _____ Packs per day? _____ I quit _____ years ago

Smokeless Tobacco: Never ___ Former ___ Snuff User ___

E-cigarette/vape: Never ___ Former ___ Current ___

Chewing Tobacco: None ___ Occasional ___ Moderate ___ Heavy ___

Caffeine intake: None ___ Occasional ___ Moderate ___ Heavy ___

Alcohol intake: None ___ Occasional ___ Moderate ___ Heavy ___
Alcohol years of use _____

Illicit Drug: None ___ Occasional ___ Moderate ___ Heavy ___

Please list any illicit drugs that you use if any: _____

Exposure to HIV: Yes _____ No _____ Unknown _____

Highest Level of Education: _____ Work Status: _____

Are you a student? Part-Time _____ Full Time _____ Not a Student _____

**Living Situation (please circle one):**

Alone with Spouse with Parents with Caregiver Group Home Assisted Living/Skilled Nursing

**Name:** _____ **Date of Birth:** _____

**Family History:** **Please check all that apply**

| Condition | Father | Mother | Father's Parents | Mother's Parents | Brother | Sister | Children |
|---|---|---|---|---|---|---|---|
| Heart Disease | | | | | | | |
| Hypertension | | | | | | | |
| Diabetes | | | | | | | |
| Cancer | | | | | | | |
| Arthritis | | | | | | | |
| Bleeding Disorder | | | | | | | |
| Kidney Disease | | | | | | | |
| Epilepsy Seizures | | | | | | | |
| Stroke | | | | | | | |
| Mental Illness | | | | | | | |
| Dementia | | | | | | | |
| Thyroid Disease | | | | | | | |
| Headache | | | | | | | |
| Increased Lipids/High Cholesterol | | | | | | | |
| Neuromuscular / Nerve or Muscle Disease | | | | | | | |