Neurology Partners Patient History Form

Name: _____ Date: _____

Main reason for today's visit with a neurologist: _____

_____

Date of birth: _____
Place of birth: _____

Highest level in school: _____

Occupation: _____

Marital status: _____

SOCIAL HISTORY

Tobacco use: ☐ Never ☐ Nonsmoker

☐ Current Smoker: packs/day: _____

# of years: _____ Quit date: _____

Cigarettes ☐ Cigar ☐ Pipe ☐ Chew ☐

Caffeine: _____ oz./day

Alcohol use:

Do you drink alcohol? ☐ Yes ☐ No

# of drinks/week: _____

Drug use:

Do you use any recreational drugs?

☐ Y ☐ N, if Yes, please list type of drug(s): _____

History of overusing prescription pain medications? ☐ Y ☐ N

SURGICAL HISTORY

Please list all prior operations: _____

_____

_____

_____

☐ Pacemaker ☐ Heart surgery

☐ Defibrillator

Please list all prior hospitalizations: _____

_____

_____

_____

MEDICAL HISTORY

☐ Rheumatic fever ☐ Heart disease

☐ Arthritis ☐ Epilepsy ☐ Polio

☐ Migraine headaches ☐ TB

☐ Diabetes ☐ Glaucoma ☐ Ulcer

☐ Back trouble ☐ High/Low BP

☐ AIDS/HIV+ ☐ Stroke ☐ Cancer

☐ Hepatitis ☐ Kidney disease

☐ Thyroid disease ☐ Bleeding tendency

☐ Other: _____

PLEASE LIST CURRENT ALLERGIES? _____

MEDICATION

Please list all medicines you are currently taking: _____

_____

_____

_____

_____

Are you currently taking any blood thinners?_____

FAMILY HISTORY

Please indicate family members (mother, father, sibling, grandparent, aunt or uncle) with any of the following conditions:

Cancer/type: _____
Tuberculosis: _____
Diabetes: _____
Heart disease: _____
High blood pressure: _____
Stroke: _____
Epilepsy: _____
Bleeding tendency: _____

Drug/Alcohol abuse: _____
Depression/anxiety: _____
Migraine headaches: _____
Thyroid disease: _____
High cholesterol: _____
Glaucoma: _____
Dementia: _____

Please indicate the present age/age of death and their current health status (good, poor)

Father: _____
Mother: _____
Siblings: _____

REVIEW OF SYSTEMS: Please check off any current symptoms you have.

Constitutional
☐ Fatigue
☐ Fevers/sweats

Psychology
☐ Anxiety
☐ Depression
☐ Trouble with sleep

Neurology
☐ Headaches
☐ Dizziness
☐ Poor coordination
☐ Memory loss
☐ Seizures
☐ Numbness/tingling
☐ Tremor
☐ Frequent falls

Cardiology
☐ Chest discomfort
☐ Palpitations
☐ Leg/foot swelling

Respiratory
☐ Shortness of breath
☐ Coughing up blood

GI
☐ Heartburn/reflux
☐ Nausea/vomiting
☐ Black tarry stools
☐ Diarrhea
☐ Constipation

Endocrinology
☐ Heat/cold sensitivity
☐ Increase in thirst

Musculoskeletal
☐ Leg cramps
☐ Neck or back pain

Urinary
☐ Frequent urination
☐ Painful urination

Ophthalmology
☐ Change in vision
☐ Eye pain

Ear/Nose/Throat/Mouth
☐ Trouble swallowing
☐ Ringing in ears
☐ Hearing loss
☐ Nosebleeds

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the staff to perform the necessary health care services I (my child) may need.

X_____ _____
Signature of patient or parent if minor Date

Notice of Privacy Practices for Neurology Partners, P.C.

Ranbir Dhillon, MD
Kathleen Kroessler, MD
Megan Callahan, MD

76 Park St.
Attleboro, MA
02703

This notice describes how medical information about you may be used and disclosed and how you may have access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by our office in any form, whether electronically, on paper, or orally, be kept confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. "HIPAA" provides penalties for individuals or companies that misuse personal health information.

As required by "HIPAA", our office has prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may disclose or exchange certain **Protected Health Information (PHI)** to doctors, nurses, pharmacists, therapists, or other medical personnel outside of this office when relevant to your medical care and safety.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may share PHI with your health insurance to receive payment for health care services we provide to you. We may also share PHI with billing companies that process our health care claims.

- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and patient quality of care.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, information about treatment, or other health-related benefits and services that may be of interest to you.

Any other uses and disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your PHI, which you may exercise by presenting a written request to the Office Manager:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

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- The right to make reasonable requests for receiving confidential communications of PHI from us by alternative means or at alternative locations.

- The right to inspect and copy your PHI. This must be requested in writing and we will respond to this request within 30 days. If you request a copy of your PHI, a fee will be charged for which you will be notified in advance.

- The right to amend your PHI. If you feel that there is a mistake in your PHI, or that important information is missing, you may request a correction. Your request must be in writing and include a reason for the request. **We will respond within 60 days of your request. We may deny your request if the PHI is: 1) correct and complete; 2) not created by this office; 3) not allowed to be shared with you; or 4) not in our records. If we deny your request, we will inform you of the reason for the denial. You may then file a written statement of disagreement, or you may ask that your original request and our denial be attached to all future reports of your PHI.** If we agree to honor your request, we will change your PHI, inform you of the change, and inform any other health care providers involved in your care of the change to your PHI.

- The right to a paper copy of this notice.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.

This notice is effective May 25, 2011, and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notices of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a copy of a revised Notice of Privacy Practices from this office.

If you feel that your privacy protections have been violated, you have the right to file written complaint about violations of the provisions of this notice or of our policies and procedures. You may file such complaints to our office or with the Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, DC 20201. Your complaint will not alter or affect the quality of care that we provide to you.

Acknowledgement

I, _____, date of birth ___/___/_____, authorize the doctors and staff of Neurology Partners to access my pharmacy records for the continuity of my care.

_____

Signature Date

I, the undersigned, have received a copy of the Notice of Privacy Policies from Neurology Partners

_____

Signature Date

Patient Information for Neurology Partners PC

PLEASE PRINT. Please fill out both sides. All information will be kept confidential.

Name:_____ Date of birth:_____

Address: _____Apt/Unit #_____

City, State, Zipcode: _____

Home phone:_____ Cell phone: _____
Preferred method of contact: Home Cell. Ok to leave message: yes no

Soc Sec #:_____ Marital Status_____ Sex ___F__M
Email address:_____

Whom may we thank for referring you to our office?_____

Name of Primary Care Doctor:_____ Phone:_____

Person to contact in case of emergency: _____
Relation:_____ Phone: _____

Primary Medical Ins._____
I D # _____ Group #_____
Subscriber name: _____ Date of birth_____
Relation to patient: _____

Secondary ins (if any)_____
I D #_____ Group #_____
Subscriber name_____ Date of birth _____

Are you being seen due to a work injury? Yes No Date of injury_____
Are you being seen due to a motor vehicle or liability injury? Yes or No
If yes, date of injury: _____

Name of Workers Comp or Liablilty Ins Co.:_____
Ins Co address: _____
Phone:_____ Person to contact: _____
Claim # _____

Do you work? Yes No
Employer Name:_____
Employer Address:_____
Employer Phone: _____

Over please >

Please read and sign.

I authorize release of any information concerning me or my child's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Doctor.

I understand that I am financially liable for worker's compensation or motor vehicle/liability claims that are not covered by my insurance.

By signing below I acknowledge that the information provided is true and accurate.

Signature_____ Date:_____