

# Lexington Neurosciences Center, PLLC

Patient Information (please complete all areas):

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN\* \_\_\_\_\_

Sex:  Male  Female      Marital Status:  Single  Married  Divorced  Widowed

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact (not living with you): \_\_\_\_\_

Phone No. \_\_\_\_\_ Alternate Phone No. \_\_\_\_\_

Relationship:  Parent  Child  Sibling  Friend  Other: \_\_\_\_\_

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Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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Primary Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ Subscriber's SSN\* \_\_\_\_\_

Patient's Relationship to Subscriber:  Self  Spouse  Child  Other: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ Subscriber's SSN\* \_\_\_\_\_

Patient's Relationship to Subscriber:  Self  Spouse  Child  Other: \_\_\_\_\_

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Are you here due to an automobile or work-related injury?  Yes  No

If so, please complete the following:

Insurance Carrier: \_\_\_\_\_ Claim # \_\_\_\_\_

Billing Address: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

*Please read and sign the following consents:*

**Consent to Treatment**

I authorize the physician(s) at Lexington Neurosciences Center, PLLC, and/or their delegates to examine and treat me according to accepted medical practices and within the scope of their abilities. I understand that it is my right to refuse any examination or treatment I do not wish to receive, however, if I choose to refuse recommended treatment, I will not hold the physicians, their delegates, or Lexington Neurosciences Center liable for any deleterious health effects or complications that may arise as a result of my refusal.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Bill**

I authorize the physicians at Lexington Neurosciences Center, PLLC, and/or their delegates to bill medical claims to my insurance carrier(s). I authorize any release of information necessary to expedite payment of insurance claims. I understand that I am responsible for all charges regardless of insurance coverage and I agree to remit payment for any charges not covered by my insurance company.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Release/Obtain Information**

I authorize the physicians at Lexington Neurosciences Center, PLLC, and/or their delegates to release information to and to obtain information from other medical practices, physicians, hospitals, laboratory and radiology providers, and any other medical entity in order to optimize or facilitate medical care provided to me. I understand that any release of information will be made under the provisions of the Health Information Portability and Accountability Act (HIPAA) and my privacy will be maintained to the greatest extent possible.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you!**

# Lexington Neurosciences Center, PLLC

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

What is the reason you are here (symptom or problem)? \_\_\_\_\_

## Social History

Married  Separated  Divorced  Single  Widowed

Current occupation: \_\_\_\_\_

Previous occupations: \_\_\_\_\_

What was the last grade in school that you completed? \_\_\_\_\_ Degree(s): \_\_\_\_\_

Do you smoke cigarettes?  Yes  No Do you smoke a pipe?  Yes  No

If so, how long have you smoked? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

Have you tried to quit?  Yes  No Were you successful?  Yes (Date: \_\_\_\_\_)  No

Do you chew tobacco?  Yes  No How much do you chew? \_\_\_\_\_

Do you drink?  Yes  No If so, how many drinks per week? \_\_\_\_\_  beer  wine  liquor

Have you used recreational drugs?  Yes  No What? \_\_\_\_\_ Do you still use?  Yes  No

Number of cups/glasses of caffeinated beverages you consume daily: Tea \_\_\_\_ Sodas \_\_\_\_ Coffee \_\_\_\_

## Medical History *(please check any of the following illnesses a doctor has diagnosed you with)*

ENT  eye injury  blindness  cataracts  glaucoma  hearing loss  vertigo  
 vision loss  sinus disease  allergies  ear infections  septal deviation

Cardiovascular  heart attack  angina  heart surgery  abnormal heart rhythm  heart failure  
 high blood pressure  high cholesterol  DVT  peripheral artery disease

Pulmonary  asthma  lung cancer  bronchitis  TB  lung disease  sleep apnea

Female  cervical cancer  ovarian cancer  uterine cancer  breast cancer  
Genitourinary  miscarriage  heavy or irregular periods

Male  prostate cancer  enlarged prostate  testicular cancer  prostate infection  
Genitourinary

*(continued next page)*

Musculo-  arthritis  back injury  fibromyalgia  lupus  low back pain  neck pain  
Skeletal  rotator cuff injury  joint pain

Dermatologic  hair loss  dermatitis  drug rash  skin cancer  vitiglio (loss of pigment)

Neurologic  seizures  stroke or TIA  neuropathy  tremor  Parkinsons disease  
 meningitis  migraines  headaches  head injury  mental retardation  
 multiple sclerosis  brain tumor  dementia  carpal tunnel syndrome  
 trigeminal neuralgia  restless legs syndrome  sleep apnea  Bell's palsy

Psychiatric  bipolar disorder  anxiety  depression  alcohol abuse  drug abuse

Endocrine  diabetes  hyperthyroidism  hypothyroidism

Hematology  anemia  leukemia  lymphoma  cancer  hemophilia  sickle cell  
 blood clots

Have you ever been exposed to HIV?  Yes  No History of hepatitis or jaundice?  Yes  No

Please list any medical problems a doctor diagnosed you with that are not listed above:

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Please list any surgeries you have had:

Surgery	Date	Surgeon's Name	Hospital
_____	_____	_____	_____
_____	_____	_____	_____

### Family History

Mother's age: \_\_\_\_\_ Living?  Yes  No Health Problems: \_\_\_\_\_

Father's age: \_\_\_\_\_ Living?  Yes  No Health Problems: \_\_\_\_\_

Number of Daughters: \_\_\_\_\_ Number Living: \_\_\_\_\_ Ages: \_\_\_\_\_

Health Problems: \_\_\_\_\_

Number of Sons: \_\_\_\_\_ Number Living: \_\_\_\_\_ Ages: \_\_\_\_\_

Health Problems: \_\_\_\_\_

(continued next page)



## Review of Symptoms

Please check any of the following symptoms you currently have, whether or not you have been diagnosed by a doctor:

### *General:*

- Daytime sleepiness  Snoring  Insomnia/poor sleep  Breath-holding during sleep  fever  
 Night sweats  Weight gain  Weight loss

### *Skin:*

- Dryness  Excessive sweating  Hair loss  Rash  Itching

### *Head, Eyes, Ears, Nose, Throat:*

- Dry mouth  Double vision  Blurry vision  Hearing loss  Ringing in ears  Dizziness  
 Sinus pain  Chronic nasal congestion

### *Lungs:*

- Cough  Shortness of breath  Sputum (phlegm) production  Wheezing

### *Heart:*

- Chest pain  Leg swelling  Palpitations or fast heartbeat

### *Gastrointestinal:*

- Heartburn  Constipation  Diarrhea  Difficulty swallowing  Nausea  Vomiting

### *Musculoskeletal:*

- Restless legs  Leg pain  Arm pain  Back pain  Neck pain  Hip pain  Joint pain  
 Joint stiffness  Muscle weakness  Muscle soreness

### *Neurologic:*

- Decreased memory  Numbness  Tingling  Headaches  Poor coordination  Tremor  
 Loss of consciousness  Seizures  Weakness

### *Psychiatric:*

- Anxiety  Depression  Hallucinations  Inability to concentrate  Suicidal thoughts  
 Irritability  Personality changes

### *Endocrine:*

- Appetite changes  Inability to tolerate cold  Inability to tolerate heat  Frequent thirst

### *Hematology:*

- Easy bruising  Easy bleeding

Any additional symptoms you would like the physician to know: \_\_\_\_\_

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***Thank you for completing this form!***