Bryan Neurology Services P.A. Patient Information Form

Patient Name ____
Title First Middle Initial Last Maiden Name

Address ____
Street City State Zip

Phone (______) ______________________ Age ____________ Date of Birth ______________________

Circle all that apply to you. Sex (M / F) Married Single Widowed Divorced Student (Full time / Part time)

Social Security # ______________________ Driver's License (State) ______ # ______________________

Employer ______________________ Address ______________________

Occupation ______________________ Work Phone (______) ______________________
If you are retired, please list your prior occupation.

Spouse/Parent/Guardian ____

Address ____
Street City State Zip

Phone (______) ______________ Date of Birth ______________ Social Security # ______________

Employer ______________________ Address ______________________

Occupation ______________________ Work Phone ______________________

PERSON TO CONTACT IN EMERGENCY (OTHER THAN SPOUSE OR PARENT)

Name ____________________________________ Phone (______) ______________

Address ____

Have you previously seen Dr. Light as a patient? [Y N] If yes, what year did you see him? ______________

Primary Care Doctor ______________________ Referring Doctor ______________________

Reason for Consult (Your symptoms) ____

How long have you had these symptoms? ____

Are these symptoms accident related?______________ Are these symptoms work related?______________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize payment directly to the physician who accepts assignment of the surgical and/or medical benefits, if any, otherwise payable to me for services as described on his submitted claim.
AUTHORIZATION TO RELEASE INFORMATION: I authorize this physician to acquire information necessary for my evaluation, treatment, or necessary to process my claim for third party benefits. I authorize this physician to use and release any information acquired for treatment, operations and payment. I acknowledge that I have reviewed the Bryan Neurology Services, P.A. Notice of Privacy Practices and I understand that I am entitled to receive a copy of this document.

SIGNED ____ **DATE** ______________________
(PATIENT / INSURED PERSON / PARENT (IF MINOR) / LEGAL GUARDIAN)

MEDICAL HISTORY

Name ______________________________ Date ______________

Medical Conditions: For any illness that **you** have now or have had in the past **circle** the word **me**. To the right of each listed illness **circle** letters for each **family member** either living or dead who has had the illness.
For family member please use F-father, M-mother, C-children, B-brother, S-sister.

	My Family		My Family		My Family
Me Anemia	[F M C B S]	**Me** Diabetes	[F M C B S]	**Me** Lung Disease	[F M C B S]
Me Anxiety	[F M C B S]	**Me** Glaucoma	[F M C B S]	**Me** Lupus	[F M C B S]
Me Arthritis	[F M C B S]	**Me** Gout	[F M C B S]	**Me** Mental Illness	[F M C B S]
Me Asthma	[F M C B S]	**Me** Headache	[F M C B S]	**Me** Parkinson's	[F M C B S]
Me Cancer	[F M C B S]	**Me** Heart attack	[F M C B S]	**Me** Seizure	[F M C B S]
Cancer location: ____________		**Me** Heart failure	[F M C B S]	**Me** Stomach ulcer	[F M C B S]
______________________		**Me** Hepatitis	[F M C B S]	**Me** Stroke	[F M C B S]
Me Cholesterol	[F M C B S]	**Me** High blood pressure	[F M C B S]	**Me** Thyroid disease	[F M C B S]
Me Cirrhosis	[F M C B S]	**Me** Kidney disease	[F M C B S]	**Me** Tuberculosis	[F M C B S]
Me Depression	[F M C B S]	**Me** Liver disease	[F M C B S]	**Me** Venereal disease	[F M C B S]

List any other serious illnesses or injuries: ______________________________

Please list all your **current medications** (including aspirin products, birth control, etc). You may attach a list.	Medication Strength	How often do you take this medication?	How long have you taken this medication?

Do you have any **medication allergies**? [Y N] If yes, please list the medicine(s). ______________________

Prior surgery: Check those that apply to you and give an approximate date.

( ) Appendix ______________ ( ) Gallbladder ______________ ( ) Hysterectomy ______________
( ) Back Surgery ______________ ( ) Heart Pacemaker ______________ ( ) Neck Surgery ______________
( ) Carotid Surgery ______________ ( ) Heart Surgery ______________ ( ) Stomach Ulcer ______________
( ) Cataracts______________ ( ) Hernia______________ ( ) Other Major Surgeries ________

____

Social History and Habits Please **circle** your answer or fill in the blank**.**

Are you right or left **handed**? [Right Left] If you have **children**, how many?_____

How many years of **education** have you completed, or what is your highest degree? _________

Do you smoke **tobacco** now? [Y N] Are you a former smoker? [Y N]

If you have smoked, how many packs per day do you smoke now? _____ in the past? ____ How many years? _______

Do you drink **alcohol** regularly? [Y N] Are you a former consumer of alcohol? [Y N]

If you drink alcohol, please list the type and quantity of alcoholic beverages you drink per week.______________________

Have you ever used marijuana, heroin, cocaine, LSD, PCP, or other **street drugs**? [Y N] ______________________