Jeffrey D. Gould, M.D.
Carly Scatton, D.O.
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Doylestown Health
Neurology

Heritage Gateway Building

Doylestown Health Neurology
1980 South Easton road, Suite 230
Doylestown, PA 18901
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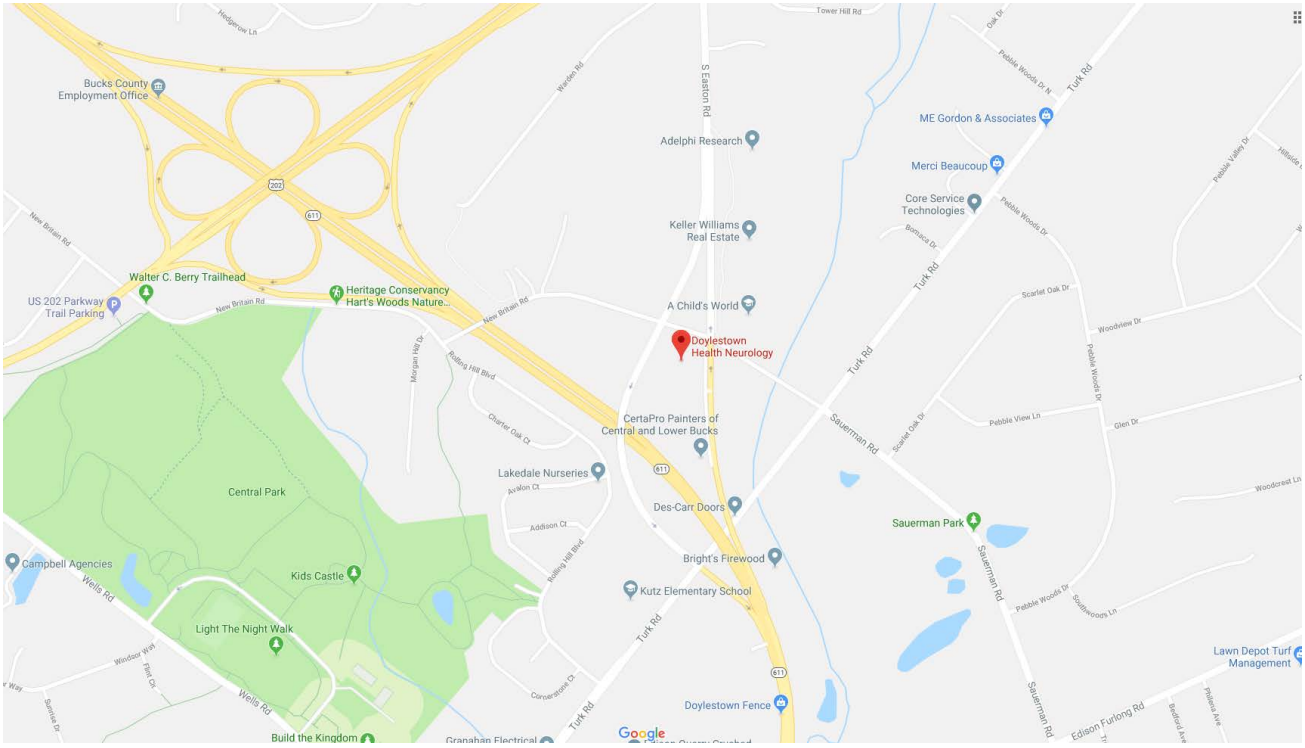

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Melissa Beans, CRNP

NEW NEUROLOGIC HISTORY AND PHYSICAL

Please tell us about yourself by completing this form. We will use this information to better understand your concerns and direct your care. Thank you

Name: _____ **Date:** _____

Birthdate: _____/_____/_____ **Age:** _____

Right or Left Handed? _____

Who is your primary doctor? _____

Which other doctors do you see? _____

_____

_____

Please list who referred you to our practice: _____

What symptoms are you having or why did your doctor refer you to us: _____

_____

_____

Social History:

Tobacco:_____ packs per day Age started___ Age quit _____ never smoked
Alcohol each day: Beer_____oz Wine_____oz Liquor_____oz socially never Age quit
Caffeine each day: Coffee____oz Soda____oz Tea ____oz none
Street drugs: occasionally never quit
Marital status: Single Married Domestic Partner Divorced Widowed
Who lives at home with you?
Number of children: _____ **Ages:** _____ **Children's Health problems?** _____ **Number of pregnancies:**_____
Education (highest grade completed):
Current Employment (if retired then write "Retired" and list longest job held):
Routine Bed Partner: yes _____ no_____

Past Health History: Please check the conditions you have or have had in the past: **NONE [ ]**

Alzheimer's **[ ]**	Arthritis **[ ]**	Asthma **[ ]**
Back injury **[ ]**	Bleeding Disorder **[ ]**	Blood Clots **[ ]**
Cancer **[ ]** type_____	High Cholesterol **[ ]**	Diabetes **[ ]**
Head injury **[ ]**	Heart attack (how many?)**[ ]** ____	Heart Disease **[ ]**
High Blood Pressure (HTN) **[ ]**	Kidney disease **[ ]**	Liver Disease **[ ]**
Lung Disease **[ ]**	Migraine **[ ]**	Movement Disorder **[ ]**
Neck Injury **[ ]**	Psychiatric Hospitalizations **[ ]**	Restless Leg Syndrome **[ ]**
Seizures **[ ]**	Sleep Apnea **[ ]**	Spontaneous Miscarriage **[ ]**
GERD **[ ]**	Stroke **[ ]**	Thyroid Disease **[ ] Hyper or Hypo**
TIA **[ ]**	Other: _____	

Prior Hospitalizations and/or Surgeries: **NONE [ ]**

Hospital	Date	Reason

Prior Tests (MRIs, CTs, EEGs, EMG/NCS, Sleep tests): **NONE [ ]**

Test	Date	Result

Current Medications (including vitamins and Over the Counter medicines, birth control pills): **NONE [ ]**

Medication	Dosage	Frequency

****Allergies**:_____ **[ ]** No known drug allergies

Family History: **[ ] Unknown**

Relative	Alive/Age Deceased	Health Problems-Diagnosis
Father		
Mother		
Brothers		
Sisters		
Grandmothers -Paternal Maternal		
Grandfathers-Paternal Maternal		
Other family history		

Immunizations: Most recent flu vaccine: ___/_____/_____ pneumonia vaccine: ____/_____/____

Please **CHECK** the problems you are having now: **[ ] none**

_____Fatigue (C)
_____Weight gain (C)
_____Weight loss (C)
_____Ringing in ears (HEENT)
_____Visual changes (HEENT)
_____Cough (R)
_____Shortness of breath (R)
_____Chest Pain (Card)
_____Bowel control loss (GI)
_____Urinary Frequency (GU)
_____Bladder control loss (GU)

_____Dizziness (N)
_____Extremity Numbness (N)
_____Extremity Weakness (N)
_____Gait disturbance (N)
_____Headaches (N)
_____Memory loss (N)
_____Tremor (N)
_____Rash (I)
_____Back Pain (M)
_____Neck Pain (M)
Other: _____

PATIENT DEMOGRAPHIC FORM

NAME: _____ **DOB:** _____

HOME ADDRESS: _____

CITY_____**STATE**_____**ZIP**_____

HOME#: _____ **CELL#:** _____

SS#: _____**MARITAL STATUS:** S M D W **(CIRCLE ONE) GENDER:** M F TG **(CIRCLE ONE)**

RACE: _____ **ETHNICITY**: _____

PRIMARY LANGUAGE SPOKEN: _____

E-MAIL ADDRESS: _____

PRIMARY DR (1st & last name): _____ **phone #:**_____

REFERRING DR (1st & last name):_____ **phone #:**_____

Preferred Lab for Blood work: **( )** Lab Corp **( )** Quest **( )** Doylestown Hospital/Wellness Center **( )** other/PCP **(CHECK ONE)**

PREFERRED PHARMACIES: ***Please provide us a copy of your card***

Local:_____ Mail order: _____

Address: _____ Address: _____

Phone # _____ Phone #:_____

EMERGENCY CONTACT: _____ relationship: _____ **phone #** (different from above) _____

IF PATIENT IS UNDER 18:

MOTHER'S NAME: _____ DAYTIME PHONE: _____

FATHER'S NAME: _____ DAYTIME PHONE: _____

ADDRESS IF DIFFERENT FROM CHILD: _____

****Attention: AUTO and WORKERS COMP PATIENTS: Please complete the following information. It is needed to submit your claims. If you do not supply ALL info, your appointment will be rescheduled. Thank you.**

Date of Injury: _____

Name of Employer: _____ Phone #_____

Address of Employer: _____

Name of Insurance Company: _____Phone #_____

Address to send claim: _____

City: _____State:_____Zip_____

Claim#:_____ Contact Name: _____

Authorization to Disclose Health Information

Name: _____

DOB: _____

I,_____ hereby authorize Doylestown Health Neurology to release ALL my Protected Health Information to:

Only Myself _____

My Spouse/Significant Other (Name) _____Phone#_____

My Children (Name) _____Phone#_____

_____Phone#_____

Other (Name) _____ Relationship _____Phone#_____

_____ I give my permission to LEAVE MESSAGES ON VOICE MAIL regarding test results, answer questions, etc.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (HIPPA) govern the terms of this Authorization. I understand that I have the right to revoke this Authorization at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that the additional information relating to the exceptions, to the right to revoke and a description of how I may revoke this Authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization, and my signature and should be sent to **Doylestown Health Neurology**.

I understand that I am not required to sign this Authorization and that the Practice may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above, and in that case, will no longer be protected by HIPAA.

This Authorization expires upon (cessation of treatment; conclusion of course treatment; release from the hospital)

I hereby acknowledge this Authorization

_____

Signature of Individual or Personal Representative Date

_____

Description of Personal Representative's Authority