Palm Beach Neurology Premiere Research Institute 4631 N. Congress avenue ste 200 West Palm Beach, FL 33407 Tel 561-845-0500 Fax 561-845-0587

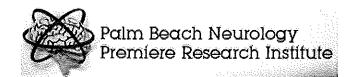
Last Name:	First Name:	MI
DOB:	Sex: Marital status: SS	N:
Address:		
	State:	
Home:	Work:	ANATOMIA Mary .
Cellular:	Email address:	
Race: Please select one		
 American Indian o White Asian Hispanic Black American Native Hawaiian Other Ethnicity: Please select or Hispanic Non-hispanic Refuse to report 		
	Medical Information	
Referred by:	Primary Care Ph	nysician
Allergies:		
Pharmacy:	Address:	
Phone:	Fox	

Emergency contact:	Phone:
Relationship:	
Who is financially responsible for this bill?_	
Insura	nce Information
Primary Insurance:	
Subscriber ID number:	Group:
Insurance address:	
Primary holder name:	DOB:
Secondary Insurance:	
Subscriber ID number:	Group:
Au	uthorization
I authorize the release of medical informatio authorize payment of medical benefits to	on necessary to process medical benefits and I for services by his/her office.
I understand that 24 hour notice is needed notice is given, there will be a \$50.00 cance diagnostic testing(EMG/EEG).	in the event of cancellation. If less than 24 hour llation fee for office visit/or \$100.00 cancellation for
If you fail to show up for an appointment, the no show fee for diagnostic testing (EMG/EE	ere is a \$50.00 no show fee for office visits and \$100 G).
It is the responsibility of the patient to keep a	an appointment – reminders are a courtesy.
l authorize medical treatment.	
SignedDat	e:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement but, in refusing we will not be allowed to process your insurance claims.

Date: _		
The un		ppy of the currently effective Notice of Privacy Practices for A copy of this signed, dated document shall be as effective
as the TREAT	original. MY SIGNATURE WILL ALSO S	ERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST OTHER ATTENDING DOCTORS IN THE FUTURE.
Please	print your name	Please <u>sign</u> your name
Legal F	Representative	Description of Authority
(This in		AN HAVE ACCESS TO YOUR MEDICAL INFORMATION: care takers who can have access to this patient's records): Relationship:
Name:		Relationship:
Name:		
I AUTH	Home Phone Confirmation Work Phone Confirmation Text Message to my Cell Phone Email Confirmation U. S. Mail / Postcard HORIZE INFORMATION ABOUT MY MI Message on Cell Phone Message on Home Phone Message on Work Phone Text Message	EDICAL HEALTH BE CONVEYED VIA:
	Email Message U. S. Mail / Postcard Any of the above	
I APPR	Phone Message Text Message Email U. S. Mail / Postcard Any of the above	ECIAL SERVICES, EVENTS or NEW MEDICAL INFO via:
Office U		epresentatives) signature on this Acknowledgement but did not because:
. W I HVA	It was emergency treatment I could not communicate with the patient The patient refused to sign The patient was unable to sign because Other (please describe)	
		Signature of Privacy Officer



PATIENT MEDICAL HISTORY

ame	Age DOB	Da	ate
ears of Education (H.S. =12) Handed:	Left Right Gen	der: 🔲 N	Iale Female
eason for Visit	MMAAA		
MEDICATIONS		Y HISTO , Excluding	
Medication: Dose	Disease	No	Yes
	Alzheimer's		
	Headache		
	Cancer		
	Epilepsy		
	Heart Disease		
	High Blood Pressure		
	Diabetes		
	Stroke		
	Anxiety, Depression, Panic Attacks or OCD		,
	Problems with Attention or Learning (i.e. AHDH)		
	Obesity		
	Other		
Drug / Allergies 1. 2.	For Women Only Menstrual Periods Regular	irregular	
3.	Last Menses		
4	Are you taking birth control pills? Yes No		
Do you smoke? Yes No	Is there a possibilit		t he promont?
How much?	is diete a possibilit	y you migh. Yes	
Do you drink Alcohol? Yes No	Are you trying to g	get pregnant	
How much?			
	Please Fill Out		VA V

Please circle below if you have had any of these symptoms/problems

Constitutional: fever / chills / signif	icant weig	tht loss or weight gain	
Eyes: visual difficulties / double visi	on		
Ears, Nose, Mouth, Throat: difficu	lty hearing	g / swallowing issues / sore throat / dizz	ziness
Cardiovascular: chest pain / shortne	ess of brea	th / high blood pressure / heart attack	
Respiratory: any pulmonary issues	wheezing	5	
Gastrointestinal: nausea / vomiting	/ diarrhea	/ blood in stool	
Genitourinary: urinary difficulties /	blood in u	nrine	
Musculoskeletal: recent injury / sign	nificant joi	nt pain	
Skin: rash / bruising			
Neurologic: history of stroke / seizu	re / numbn	ess / weakness / headache / neck pain /	back pain
<u>Psychiatric:</u> sadness / depression / si	ignificant a	anxiety / suicidal	
Endocrine: diabetes / thyroid proble	ms		
Hematologic / Lymphatic: low bloc	od count / t	plood disorders	
History of Cancer: yes / no type:			
Surgeries or Hospitalizations	Date	Surgeries or Hospitalizations	Date
1.		5.	
2.		6.	·
3.		7.	
4.		8.	