

**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: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____

Cellular: _____ Email address: _____

Race: Please select one

- American Indian or Alaska Native
- White
- Asian
- Hispanic
- Black American
- Native Hawaiian
- Other

Ethnicity: Please select one

- Hispanic
- Non-hispanic
- Refuse to report

Medical Information

Referred by: _____ Primary Care Physician _____

Allergies: _____

Pharmacy: _____ Address: _____

Phone: _____ Fax: _____

Emergency contact:_____ Phone:_____

Relationship:_____

Who is financially responsible for this bill?_____

Insurance Information

Primary Insurance:_____

Subscriber ID number:_____ Group:_____

Insurance address:_____

Primary holder name:_____ DOB:_____

Secondary Insurance:_____

Subscriber ID number:_____ Group:_____

Authorization

I authorize the release of medical information necessary to process medical benefits and I authorize payment of medical benefits to _____ for services by his/her office.

I understand that **24 hour notice** is needed in the event of cancellation. If less than 24 hour notice is given, there will be a \$50.00 cancellation fee for office visit/or \$100.00 cancellation for diagnostic testing(EMG/EEG).

If you fail to show up for an appointment, there is a \$50.00 no show fee for office visits and \$100 no show fee for diagnostic testing (EMG/EEG).

It is the responsibility of the patient to keep an appointment – reminders are a courtesy.

I authorize medical treatment.

Signed_____ Date:_____

**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 undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for _____ A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

Please **print** your name

Please **sign** your name

Legal Representative

Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR MEDICAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY MEDICAL APPOINTMENTS,
TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY MEDICAL HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Text Message
- ☐ Email Message
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW MEDICAL INFO** via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

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



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PATIENT MEDICAL HISTORY

Name _____ Age _____ DOB _____ Date _____

Years of Education (H.S. =12) _____ Handed: ☐ Left ☐ Right Gender: ☐ Male ☐ Female

Reason for Visit _____

MEDICATIONS

Medication: Dose

FAMILY HISTORY
(Relatives, Excluding Self)

Disease	No	Yes
Alzheimer's	<input type="checkbox"/>	
Headache	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	
Anxiety, Depression, Panic Attacks or OCD	<input type="checkbox"/>	
Problems with Attention or Learning (i.e. ADHD)	<input type="checkbox"/>	
Obesity	<input type="checkbox"/>	
Other	<input type="checkbox"/>	

Drug / Allergies

1. _____
2. _____
3. _____
4. _____

Do you smoke? ☐ Yes ☐ No

How much? _____

Do you drink Alcohol? ☐ Yes ☐ No

How much? _____

For Women Only

Menstrual Periods

☐ Regular ☐ irregular ☐ none

Last Menses _____

Are you taking birth control pills?

☐ Yes ☐ No

Is there a possibility you might be pregnant?

☐ Yes ☐ No

Are you trying to get pregnant?

☐ Yes ☐ No

Please Fill Out Page 2



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

Constitutional: fever / chills / significant weight loss or weight gain

Eyes: visual difficulties / double vision

Ears, Nose, Mouth, Throat: difficulty hearing / swallowing issues / sore throat / dizziness

Cardiovascular: chest pain / shortness of breath / high blood pressure / heart attack

Respiratory: any pulmonary issues / wheezing

Gastrointestinal: nausea / vomiting / diarrhea / blood in stool

Genitourinary: urinary difficulties / blood in urine

Musculoskeletal: recent injury / significant joint pain

Skin: rash / bruising

Neurologic: history of stroke / seizure / numbness / weakness / headache / neck pain / back pain

Psychiatric: sadness / depression / significant anxiety / suicidal

Endocrine: diabetes / thyroid problems

Hematologic / Lymphatic: low blood count / blood disorders

History of Cancer: yes / no type: _____

Surgeries or Hospitalizations	Date	Surgeries or Hospitalizations	Date
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____