Newton-Wellesley Neurology Associates, P.C.
www.nwneurology.com / www.patientgateway.org
2000 Washington St. Suite 567 (Green Bldg)
Newton Lower Falls, MA 02462
Phone 617-928-1500 * Fax 617-630-0860

# PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT

**GENERAL INFORMATION (Please Print)**

First Name _____ M____ Last Name _____

Address: Street _____

City/State/Zip _____

Home Phone ___ (_____) _____ Preferred# Y / N E-Mail Address _____

Cell Phone ___ (_____) _____ Preferred# Y / N Work Phone ___ (_____) _____

Social Security Number _____ Date of Birth _____

Marital Status M___ S___ W___ D___ Partner___ Gender (Sex) M [ ] F [ ]

Emergency Contact _____ Phone Number (Emergency Contact) (_____) _____

Relationship _____

Employer _____ Occupation _____

**Please circle Yes or No for each** **Is TODAY's VISIT related to any of the following:**

Motor Vehicle Accident **( Y / N )** Work Related Accident **( Y / N )** Other Liability **( Y / N )** _____

**Primary Care MD** Name _____ Phone (_____) _____

(City, State, Zip) Address _____

**Reason for your Current Visit** _____

## RELEASE of MEDICAL RECORDS

**I authorize release of my medical records to me upon request**: _____

Signature of Patient or Guardian

**FINANCIAL:** By signing below:

- I understand that I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations. I understand that I am responsible for payment in full of all charges.
- I understand that if I fail to pay any charges owed by me that my financial account may be turned over to a collection agency and ultimately may be filed against my credit report.
- I request that payment of authorized Medicare and other insurance benefits be paid directly to Newton-Wellesley Neurology Associates, PC. I also authorize Newton-Wellesley Neurology Associates, PC to release all information necessary for the processing of insurance claims to CMS, its agents or any other insurance company to determine the benefits payable for related services.
- **I understand that if I fail to show up for an appointment without prior notification or cancel an appointment with less than 24 business hours notice that I will be subject to a Service Fee.**

Signature _____ Date _____

Signature of Patient or Guardian

## Electronic Communication:

- NWNA participates with Partners Gateway; a secure communication system.
- To access this system, please register at **patientgateway.org**
- This system will allow you to communicate electronically and securely with our office and physicians.
- For an in depth or complex discussion with your physician, *please call the office to schedule an appointment*.
- Our physicians e-mail accounts are not secure and should not be used for patient communication.

## INSURANCE INFORMATION

**Please have your insurance card and a photo ID ready when you visit the office. We will make a photocopy.**

**PLEASE CONTINUE ON OTHER SIDE**

NEWTON-WELLESLEY NEUROLOGY ASSOCIATES

# NEW PATIENT

# MEDICAL HISTORY and REVIEW OF SYSTEMS

## SOCIAL HISTORY

**Please circle (Y)ES OR (N)O**

| | |
|---|---|
| Use of tobacco | Y N |
| Use of recreational drugs | Y N |
| Use of alcohol | Y N |

**Please indicate Marital Status**

Single Married
Divorced Widowed

## FAMILY HISTORY

Name: _____

**Please circle (Y)ES OR (N)O**

| | Mother | Father | Siblings |
|---|---|---|---|
| Alzheimer's disease or Dementia | Y N | Y N | Y N |
| Brain tumor | Y N | Y N | Y N |
| Depression | Y N | Y N | Y N |
| Headaches | Y N | Y N | Y N |
| Multiple Sclerosis | Y N | Y N | Y N |
| Muscle disease/Nerve disease | Y N | Y N | Y N |
| Parkinson's disease | Y N | Y N | Y N |
| Seizures/Epilepsy | Y N | Y N | Y N |
| Stroke | Y N | Y N | Y N |

## PAST MEDICAL HISTORY and PREVIOUS EVALUATIONS & TREATMENTS

**Please circle (Y)ES OR (N)O**

| | | |
|---|---|---|
| Back or Neck Surgery Y N | Hypertension Y N | CT Scan of Head Y N |
| Brain Surgery Y N | Learning Disabilities Y N | EEG Y N |
| Cancer Y N | Multiple Sclerosis Y N | EMG/ Nerve Conduction Study Y N |
| Depression Y N | Risk factors for AIDS Y N | Evaluation by a Neurologist Y N |
| Diabetes Y N | Strokes Y N | MRI of: Y N |
| Epilepsy/Seizures Y N | Biopsy - Muscle Y N | Back Y N |
| Head Trauma Y N | Biopsy - Nerve Y N | Brain Y N |
| | Spinal Tap Y N | Neck Y N |

## PLEASE LIST ANY OTHER PERTINENT PAST MEDICAL HISTORY:

_____

_____

*If your family doctor is part of NWH* ***WE CAN PRINT A COPY OF MEDICATIONS and ALLERGIES*** *- PLEASE ASK!*

**MEDICATIONS and SUPPLEMENTS:** /

*Please also indicate dosage and quantity if known* /

/

## ALLERGIES:

_____

**Please circle (Y)ES OR (N)O**

| Please enter your height & weight | HEIGHT | WEIGHT |
|---|---|---|
| | | |

| | | |
|---|---|---|
| **CARDIOVASCULAR** | **GENITOURINARY** | **GENERAL** |
| Chest Pain Y N | Change in Menses Y N | Dizzy Spells Y N |
| Palpitations Y N | Urination - Bloody Y N | Fatigue/Loss of Energy Y N |
| **EAR/NOSE/THROAT** | Urination - Frequent Y N | Headaches - New Y N |
| Loss of Hearing Y N | Urination - Incontinence Y N | Increased Thirst Y N |
| Loss of Smell Y N | | Persistent Fever Y N |
| **EYES** | **HEMATOLOGY/LYMPHATIC** | **MUSCULOSKELETAL** |
| Double Vision Y N | Anemia Y N | Joint - Swelling Y N |
| Vision Loss/Blindness Y N | Lymph node Enlargement Y N | Muscular Weakness Y N |
| **GASTROINTESTINAL** | **PSYCHIATRIC** | **NEUROLOGICAL** |
| Abdominal Pain Y N | Anxiety or Phobia Y N | Dizziness Y N |
| Constipation Y N | Depression Y N | Facial Pain Y N |
| Diarrhea Y N | **RESPIRATORY** | Fainting Y N |
| Difficulty Swallowing Y N | Persistent Cough Y N | Language Problems Y N |
| Loss of Appetite Y N | Shortness of Breath Y N | Memory Loss Y N |
| Nausea Y N | **SKIN** | Sleeplessness Y N |
| Vomiting Y N | Bruising - Excessive Y N | Speech Change Y N |
| Weight Gain Y N | Skin - Eruptions Y N | Tremor Y N |
| Weight Loss Y N | Skin - Rash Y N | Trouble Walking Y N |