

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 Cell Phone() _____ Preferred# Y / N

E-Mail Address _____

Social Security Number - - Date of Birth / /

Marital Status M ___ S ___ W ___ D ___ Partner ___ Gender (Sex) M [] F []

Do you require American Sign Language Interpretation? (Y / N)

Do you require Spoken Language Interpretation? (Y / N) If Yes, please specify language _____

Please note: For ASL or other translation, we require advanced notification.

Employment Status: Full-Time Part-Time Retired Other _____

Primary Care MD Name _____

Address (City, State) _____

Reason for your Current Visit (signs / symptoms / diagnosis?) _____

Is TODAY's VISIT related to any of the following?

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

Is someone other than your health insurance carrier responsible for today's charges? (Y / N)

b) Has any organization (i.e. work, adoption agency, humanitarian agency) requested that you get medical clearance and you currently have no related neurological signs/symptoms/diagnosis)? (Y / N) _____

c) Are you seeing the doctor to assess for neurological risk, based on a family history, of a specific diagnosis (i.e. aneurysm, stroke, multiple sclerosis) and you have no history, of neurological signs/symptoms, related to this diagnosis? (Y / N) _____

Diagnosis/Disease?

PLEASE CONTINUE ON OTHER SIDE