



PINEHURST NEUROLOGY

10 Page Drive, Pinehurst, North Carolina 28374 Phone: 910-295-6868 Fax: 910-295-1514

PATIENT INTAKE AND CONSENT FORM

First Name _____ MI _____ Last Name _____ Address _____ City _____ State _____ Zip _____ Responsible Party _____ Address _____ City _____ State _____ Zip _____ Phone Number _____ Patient Relationship to Responsible Party: _____	Date of Birth ____/____/____ Today's Date ____/____/____ Age _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W Cell Phone (____) _____ - _____ Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Social Security # _____ Provide email to Join & use preferred method of contact!!! Do you or a family member have a FollowMyHealth Patient Portal Login? <input type="checkbox"/> Y <input type="checkbox"/> N Name of person requesting access _____ Relationship to patient _____
FollowMyHealth access info: Please provide email address of the person requesting access to the portal: Email: _____@_____	
Employer _____ Address _____ City _____ State _____ Zip _____	Occupation _____ Contact at Employer _____ Phone Number (____) _____ - _____
Referring Physician _____	Primary Care Physician: _____
Primary Insurance _____ Group # _____ ID # _____ Insured Employer _____ Relationship to Insured _____	Insured Name _____ Address _____ City _____ State _____ Zip _____ Phone (____) _____ - _____ Insured Date of Birth ____/____/____ Insured Sex: Sex <input type="checkbox"/> M <input type="checkbox"/> F
Secondary Insurance _____ Group # _____ ID # _____ Insured Employer _____ Relationship to Insured _____	Insured Name _____ Address _____ City _____ State _____ Zip _____ Phone (____) _____ - _____ Insured Date of Birth ____/____/____ Insured Sex: Sex <input type="checkbox"/> M <input type="checkbox"/> F
Emergency Contact _____	Daytime Phone Number (____) _____ - _____

Initial Each Entry Below

<p>CONSENT TO TREATMENT: I hereby consent to such treatment or equipment as prescribed by all physicians and technicians treating me. I understand that Pinehurst Neurology, PA will at all times exercise good faith in this relationship. This consent is intended as a waiver of liability for such treatment except acts of negligence. _____</p>
<p>TREATMENT OF MINORS/ADULTS: I, as a parent/guardian/POA of a patient receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____</p>
<p>LIABILITY: I know and agree that Pinehurst Neurology is not responsible for loss or damage to personal valuables. _____</p>
<p>WAIVER AND RELEASE: I hereby release, discharge and acquit Pinehurst Neurology, it's representatives, affiliates, employees, or assigns, of and from any and all liability, claim, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to receive or allow emergency and or medical services, including but not limited to ambulance, Emergency Medical Technician, physician or urgent care services. _____</p>
<p>AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Pinehurst Neurology and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. <i>I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.</i> I agree that this authorization shall be valid until rescinded in writing or replaced by one of the later date. _____</p>
<p>NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____</p>
<p>I certify that all of the information provided herein is true and correct.</p>
<p>Patient/Guardian/POA Signature _____ Witness Signature _____</p>

SYSTEMS REVIEW

Patient's Name _____ D.O.B. _____

Do you have any of the following?

General			Gastrointestinal		
Weight Gain	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Frequent Nausea Or Vomiting	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Weight Loss	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Difficulty Swallowing	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Loud Snoring	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Pain In Abdomen	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Skin			Musculoskeletal		
Rashes, Hives, Eczema	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Painful Or Swollen Joints	No <input type="checkbox"/>	Yes <input type="checkbox"/>
			Back Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Head-Eyes-Ears-Throat			Back Injury	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do You Wear Glasses	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Double Vision	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Hematologic		
Poor Hearing	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Slow To Heal After Cuts	No <input type="checkbox"/>	Yes <input type="checkbox"/>
			Anemia	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Neck			Excessive Bruising	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Stiffness	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Thyroid Trouble	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Endocrine		
Enlarged Glands	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Thyroid Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
			Hormone Replacement	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Breasts			Intolerance To Hot/Cold	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Lumps	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Nipple Discharge	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Cardiovascular		
			Shortness Of Breath W/Walking Or Lying Down	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Respiratory			High Blood Pressure	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Chronic Cough	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Irregular Heartbeat	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Asthma Or Wheezing	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Difficulty Breathing	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Psychiatric					
Depression	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Difficulty Sleeping	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Crying Spells	No <input type="checkbox"/>	Yes <input type="checkbox"/>			
Nervousness	No <input type="checkbox"/>	Yes <input type="checkbox"/>			

Physician's Signature

Date



Authorization to Discuss Medical Information

Patient Name: _____ **Patient Date of Birth:** _____

Representative authorized to discuss/review information:

Name: _____

Address: _____

Phone: _____

Relationship to Patient: _____

Extent of Authorization (choose ONE):

A: Complete medical record including, but not limited to: appointments, medications, lab results, imaging study results, test results, plan of care. Includes records relating to: mental health, HIV/AIDS, alcohol/drug abuse).

B: Complete medical record with the exception of: mental health records, communicable disease information (HIV/AIDS), alcohol/drug abuse treatment, other: _____

Effective Period:

This Authorization will remain in effect until:

A: No Expiration Date

B: Expires _____ (specify expiration date or event)

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the patient.

Signature of Patient or Personal Representative

Date: _____

Print or Type Name of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)