

# Bergen Neurology Consultants

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Epilepsy – General Neurology – Sleep Disorders – Movement Disorders – Critical Care – Neuromuscular Disorders/EMG  
Pain Management – Stroke

## **PLEASE COMPLETE ALL 3 PAGES**

Date: _____	Name: _____
Address: _____	City: _____ State: _____ Zip: _____
Home phone: _____	Work Phone: _____
Date of Birth: _____	Social Security Number: _____
E-Mail Address: _____	
Emergency Contact (Name & Number): _____	
Referring physician (name): _____	
Address: _____	City: _____ State: _____ Zip: _____
Phone: _____	
Other current physicians (name, address, and phone number): _____	
_____	
_____	

### **INSURANCE INFORMATION**

Primary company: _____
Name of Insured: _____ Relationship: _____
Employer: _____ D.O.B. of insured: _____
ID number: _____ Group number: _____
Address: _____
Phone: _____
Secondary company: _____
Name of Insured: _____ Relationship: _____
Employer: _____ D.O.B. of insured: _____
ID number: _____ Group number: _____
Address: _____
Phone: _____

### **AUTHORIZATION FOR BILLING AND RECORD RELEASE**

I understand that I am financially responsible for all fees, including deductibles, regardless of insurance coverage. If the doctor has agreed to accept my insurance, I request that all benefits be paid directly to <i>Bergen Neurology Consultants</i> .
Signature of patient or legal guardian: _____
I authorize <i>Bergen Neurology Consultants</i> to release to (or obtain from) my other treating physicians or health care facilities my medical records. If I request a copy of records for myself or a physician, I agree to a search fee of \$10 and a copying fee not to exceed \$1/page.
Signature of patient or legal guardian: _____

**PLEASE TURN THE PAGE TO COMPLETE PAGES 2 AND 3**

**PLEASE COMPLETE ALL QUESTIONS**

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
 Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Which is your dominant hand (e.g., write, eat): \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**What Is The Problem For Which You Have Come To See Us:** \_\_\_\_\_

When did this problem start: \_\_\_\_\_

Do you have or have you had any of the following problems? Explain these or others below.

	yes	no		yes	no		yes	no
Memory loss			Unexplained fever			Cirrhosis		
Alzheimer's disease			Unexplained weight loss			Bleeding in the urine		
Loss of consciousness			Fatigue			Difficulties urinating		
Dizziness/vertigo			Heart attack			Incontinence		
Seizures/epilepsy			Angina			Sexual difficulties		
Stroke/TIA			Heart failure			Joint pains		
Visual loss			Heart arrhythmia			Arthritis		
Double vision			Heart valve problem			Rash		
Loss of Hearing			Heart murmur			Diabetes mellitus		
Ringling in the ears			High blood pressure			Thyroid problem		
Loss of smell			High Cholesterol			Depression		
Speech difficulties			Poor circulation			Anxiety		
Swallowing difficulties			Shortness of breath			Hallucinations		
Headache			Unexplained cough			Allergies		
Face pain			Asthma			Tuberculosis		
Neck pain			COPD/emphysema			HIV/AIDS		
Back pain			Bronchitis			Anemia		
Leg pain/sciatica			Pulmonary embolus			Easy bleeding/bruising		
Muscle pain			Blood clot in legs			Cancer		
Weakness			Unexplained nausea/vomiting					
Clumsiness			Unexplained diarrhea			<b>Snoring</b>		
Tremor/shaking			Stomach/intestinal bleeding			<b>Trouble falling asleep</b>		
Involuntary movements			Ulcer			<b>Gasping breaths at night</b>		
Difficulty walking			Jaundice			<b>Daytime drowsiness</b>		
Parkinson's disease			Hepatitis					

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all hospitalizations and operations: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Medications:

<u>name</u>	<u>dose (mg)</u>	<u>doses/day</u>	<u>name</u>	<u>dose (mg)</u>	<u>doses/day</u>

Medication Allergies: \_\_\_\_\_

Family History	alive/dead (age)	Illnesses
Mother	_____	_____
Father	_____	_____
Brother/Sister	_____	_____
Brother/Sister	_____	_____
Brother/Sister	_____	_____
Brother/Sister	_____	_____
Brother/Sister	_____	_____
Child	_____	_____
Child	_____	_____
Child	_____	_____

List any neurological diseases in your family: \_\_\_\_\_  
\_\_\_\_\_

Are you currently working? yes no. Occupation: \_\_\_\_\_

Marital Status: single married separated/divorced widowed.

Education: less than high school grad high school grad college grad

Do you *currently* smoke? yes no. How much? \_\_\_\_\_

If no, did you *ever* smoke? yes no. When did you stop? \_\_\_\_\_

Do you *currently* drink any alcohol? yes no. How much? \_\_\_\_\_

If no, did you *ever* drink alcohol? yes no. How much and when? \_\_\_\_\_

Do you *currently* use any recreational drugs? yes no. Which one(s)? \_\_\_\_\_

If no, did you *ever* use recreational drugs? yes no. Which one(s)? \_\_\_\_\_

Do you currently exercise? yes no. What type and how much? \_\_\_\_\_

With whom do you live? \_\_\_\_\_

If a woman, are you pregnant? yes no. If not, when was your last menstrual period? \_\_\_\_\_. Or, if menopausal, at what age? \_\_\_\_\_