

# Bergen Neurology Consultants

Date: \_\_\_\_\_  
Last name: \_\_\_\_\_  
First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_  
Previous name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
SSN: \_\_\_\_\_

**Referring physician:**

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**Primary physician (if different):**

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**Telephone #:**

Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
Work: \_\_\_\_\_ ext: \_\_\_\_\_

**Emergency contact:**

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Pharmacy:**

<i>Local:</i>	<i>Mail Order:</i>
Name: _____	_____
Address: _____	_____
Ph: _____	_____
Fx: _____	_____

**Employer/ school:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

**Email:** \_\_\_\_\_

**Primary insurance:** \_\_\_\_\_  
ID#: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Name of insured: \_\_\_\_\_  
Date of birth of insured: \_\_\_\_\_

**Secondary insurance:** \_\_\_\_\_  
ID#: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Relation to insured: \_\_\_\_\_  
Employer of insured: \_\_\_\_\_

**Reason for visit:** \_\_\_\_\_

- I understand I am financially responsible for all fees, including deductibles, regardless of insurance coverage
- I request all benefits be paid directly to *Bergen Neurology Consultants*
- If I request a copy of my entire medical records, I agree to a search fee of \$10 and a copying fee not to exceed \$1/page
- I consent to the provisions of the HIPPA privacy regulations, which were provided to me by *Bergen Neurology Consultants* (also available on [www.bergenneurology.com](http://www.bergenneurology.com))

Signature of patient or legal guardian: \_\_\_\_\_

If completed in last 6 months + no change, check here \_\_\_\_\_

<b>Problem</b>	no	yes	<b>Medications</b>	dose	doses/day
chest pain					
shortness of breath					
abdominal pain					
fever/chills					
pain urinating					
rash					
depression					
anxiety					
weight change					
visual disturbance					
hearing loss			<b>Family history</b>		
anemia			mother		
swollen lymph nodes			father		
HIV/AIDS			brother/sister		
easy bruising			children		
cancer			neurological diseases in family?		
diabetes					
heart disease			<b>Social history</b>		
high blood pressure			marital status		
headache			working		
tingling/numbness			regular exercise		
seizure			education		
dizziness			occupation		
memory problems			recreational drugs		
tremor			with whom do you live?		
weakness			are you pregnant?		
loss of sensation			last menstrual period?		
fainting or lightheadedness			menopause?		
trouble with balance			recent travel		
clumsiness			caffeine		
trouble walking			smoking		
pain			alcohol		
falls					
stroke/TIA			<b>Vital signs</b>		
ringing in ears			height (inches)	weight (lbs)	
loss of smell					
difficulty speaking			<b>Medical history</b>		
difficulty swallowing					
involuntary movements					
difficulty urinating					
loss of control of urine			<b>Allergies</b>		
sexual difficulty					
snoring					
trouble falling asleep			<b>Surgeries</b>		
daytime drowsiness					
awaken feeling tired					