ANNAPOLIS NEUROLOGY ASSOCIATES
NEW PATIENT INFORMATION

Patient Name_____Date of Birth_____Today's Date_____

Patient Information

Address_____ City/State/Zip_____

Gender_____ Preferred method of contact? Home, Work, Cell, email, other (Circle)
Home Phone_____Work Phone_____Cell Phone_____E-mail _____

E-Mail _____ May we leave a message with medical information? • Home • Work • Cell (Circle)

Employer_____ Occupation_____

Referring Physician_____ Primary Care Provider _____

Race_____ Ethnicity_____ Language_____

Responsible Party

• Self • Spouse • Parent • Other

Resp. Party Name_____ Phone _____
Address_____
Date of Birth_____ Relationship_____

Insurance Information

Reason for Today's Visit • Illness Auto Accident • Job Injury • Other Injury

- If auto accident or job injury, please notify the receptionist immediately. If other injuries, date & brief description.
  _____

Primary Insurance _____
**Insurance company nam,e, Policy ID, Group number and medical claims address
Insured's Name_____ DOB_____

Relationship to Patient • Self • Spouse • Parent • Other

Secondary Coverage._____
**Insurance company nam,e, Policy ID, Group number and medical claims address

Insured's Name_____ DOB_____

Relationship to Patient • Self • Spouse • Parent • Other

I have completed this form entirely and certify that I am the patient or duly authorized agent of the patient to furnish the information requested. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered.

Patient/ Resp. Party Signature _____Date_____

Annapolis Neurology Associates
Patient Intake Form

Patient Name:_____
Date:_____

REASON FOR VISIT:
**** Please give a detailed description of the reason for your visit
_____

_____

Your current Height _____ Your current weight _____

When did the pain or problem start? _____

MEDICAL HISTORY:

Diabetes		Yes	No	Headaches		Yes	No
High blood pressure	Yes	No		Seizures/Epilepsy	Yes	Stroke	
Heart Disease	Yes	No		Parkinson's Disease	Yes	No	
Irregular heart beat	Yes	No					
Cancer	Yes	No					
Arthritis		Yes	No	Other Medical Conditions:_____			

_____

PRIOR HOSPITALIZATIONS/SURGERIES:	When	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES TO MEDICATIONS:
** Do you have any allergies to medications? Yes No (Circle)
Please list medications that you have allergies to and what the reaction is:
_____

MEDICATIONS:
What pharmacy would you like any prescriptions to be sent to**?** _____

Please list all medications taken recently, including vitamins and supplements. Attach a separate sheet if needed.

1._____	4._____	7._____
2._____	5._____	8._____
3._____	6._____	9._____

SOCIAL HISTORY:

Marital Status	Single	Married	Separated	Divorced	Widowed
Caffeinated beverages:	Coffee	Tea	Sodas	Other	
Alcohol Use	Never	Rarely	Moderate	Daily	_____drinks per day/week
Tobacco Use	Never	Quit - date_____	Current – packs per day_____		
Illicit Drug Use	Never	Type/Frequency_____			

FAMILY MEDICAL HISTORY:

Family Member:	Age	Gender	Medical Condition	If Deceased, cause of death and age at death
Father	____		_____	_____
Mother	____		_____	_____
Siblings	____	M / F	_____	_____
	____	M / F	_____	_____
	____	M / F	_____	_____
Children		____ M / F	_____	_____
	____	M / F	_____	_____

Please list the names and complete mailing addresses of any doctors that you wish to receive a copy of your neurology visits. Please include your primary care provider.

Physician Name:_____ Telephone:_____

Address:_____ Fax:_____

E-mail: _____

Physician Name:_____ Telephone:_____

Address:_____ Fax:_____

E-Mail: _____

Physician Name:_____ Telephone:_____

Address:_____ Fax:_____

E-Mail: _____

Physician Name:_____ Telephone:_____

Address:_____ Fax:_____

E-Mail: _____

Physician Name:_____ Telephone:_____

Address:_____ Fax:_____

E-Mail: _____

Physician Name:_____ Telephone:_____

Address:_____ Fax:_____

E-Mail: _____

HEADACHE QUESTIONNAIRE

Please fill this out if you are coming in for headaches. Circle the appropriate answers.

How long have you had headaches? _____ days / weeks / months / years

How often do they occur? _____ times per day / week / month / year

How long do the headaches typically last? _____ seconds / minutes / hours / days

Severity of headaches on a scale of 0-10 (If it varies, please give a range
_____

What does the headache feel like? Choose up to 3 throbbing / aching / burning / sharp / stabbing / constant / vice-like/ pounding / pressure
other:_____

Where are the headaches? left / right / around the eyes / temples / top of head / back of head / neck

Do you have any associated symptoms? light sensitivity / sound sensitivity / nausea / vomiting
droopy eyelid / congestion / runny nose / dizziness vertigo / red or tearing eye / fever
vision disturbance /snoring at night other: _____

Do any of the following trigger your headaches? weather changes / lack of sleep / alcohol/
/
caffeine / high blood pressure / position (lying down) / exertion / stress or anxiety / time of day
menstruation / foods / other: _____

What makes the headache better? sleep / moving around / dark room / massage / heat / ice / time/waiting Medication / other: _____

Have you taken any of the following medications on a daily basis to prevent headaches? (circle)

Aimovig
Ajovy
Botox
Butterbur
Baclofen
Calan (verapamil)
Candesartan
Cymbalta
Depaklote (Valproic Acid)
Effexor (venlafaxine)
Emgality
Elavil (amitriptyline)
Feverfew
Flexeril (cyclobenzaprine)
Inderal (propranolol)
Lamictal (lamotrigine)
Lexapro
Lithium
Losartan
Lyrica
Magnesium
Neurontin (gabapentin)
Nurtec
Pamelor (nortriptyline)
Prozac (fluoxetine)
Qulipta
Riboflavin (B2)
Topamax (topiramate)
Vyepti
Zoloft
Zonegran (zonisamide)
Other : _____

Have you taken any of the following medications to get rid of a headache?

Aleve (naproxen)
Alsuma
Amerge (naratriptan)
Aspirin
Axert
Cambia
Cefaly
Compazine
DHE
Diclofenac
Excedrin
Fioricet
Indocin (indomethacin)
Imitrex (sumatriptan)
Maxalt
Midrin
Migranal
Motrin/Advil (ibuprofen)
Nerivio
Nerve Block
Nurtec
Periactin (cyproheptadine)
Phenergan (promethazine)
Reglan
Relpax
Sprix
Steroids
Sumavel
Toradol (ketorolac)
Treximet
Tylenol (acetaminophen)
Zipsor (diclofenac)
Ubrelvy
Zofran
Zomig
Other: _____

Please indicate to the best of your knowledge the reason you stopped any of the above medications:

_____

_____

Extra space provided to list any additional information you would like the provider to know about your condition:

_____

_____

HIPAA and No Show Agreement:

Assignment and Release:

- ☐ I hereby assign my insurance benefits to be paid directly to Daniel Hexter MDPA dba Annapolis Neurology Associates
- ☐ I understand that I am financially responsible for all noncovered "denied" services, copays, deductibles. coinsurance, MVA/WC cases and after hours calls
- ☐ I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan
- ☐ I am responsible for payment in full within 30 days of receipt of a bill for services provided. If I am unable to pay in full within 30 days, it is my responsibility to contact the office to arrange a payment plan with the management and or the billing department
- ☐ I authorize the provider or designated representative to contact me by telephone, email or text message about appointments, billing and medical care. (A personal message may be left on your voicemail
- ☐ I authorize the physician to release any medical information required to process claims and continuity of care.
- ☐ I acknowledge that I have viewed and been given a copy of the "Notice of Privacy Practices" which includes the mega HIPAA REvisions 2013.

I Authorize the disclosure of my protected health information to (friends, family members and or caregivers

PHI released to:

_____

PHI released to:

_____

Please print and sign your name to confirm that you have reviewed this document:

_____

Cancellation Policy:

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving treatment. Therefore, Annapolis Neurology Associates reserves the right to charge a fee for missed appointments ("no show") that are not canceled within a 24 hours advanced notice: $35.00 for missed office visits. $50.00 for missed procedures. No show fees are subject to change without notice. "NoShow" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12 moonth period may result in termination from the practice. Thank you for your understanding and consideration as we strive to best serve the needs of all our patients.

Please read the Cancellation Policy and print and sign your name in acknowledgement of this policy

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