Tampa Neurology Associates

New Patient Form- Multiple Sclerosis

Name: _____ Age: _____ Date of Visit: _____

Date of Birth: _____ Referring Physician: _____

Primary Care Physician: _____

Main Reason for Visit Today: _____

Email Address: _____ Phone Number: _____

Phone Type: _____ Pharmacy Name/Location: _____

Check if you have past medical history of the following:	**Yes**
Arthritis	
Cancer	
High cholesterol	
Depression	
Diabetes	
Heart rhythm problems	
Heart attack	
High blood pressure	
HIV/AIDS	
Hepatitis	
Lung/pulmonary disease	
Memory loss	
Migraine headaches	
Recurrent infections	
Seizure	
Stroke	

Current Medications:

Name	**Dose**	**Frequency**

Social History:
Martial status: S/M/D/W
Occupation:
_____
Children: Yes/No
Tobacco: Yes/No Quit? Yes/No When?
_____
Alcohol: Yes/No Frequency? _____
Drug use? Yes/No
Highest Level of Education: _____
Where were you born? _____

Medication Allergies:

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States/countries lived in:

_____

Past Surgeries:

Date	Type of Surgery

Any recent or ongoing symptoms of the following: (Mark with an "X")

	Denies	Admits
Constitutional: Fever		
Chills		
Weight loss		
Fatigue		
Sweating		
Skin: Rash		
Skin cancer		
Itching		
Psoriasis		
Eczema		

Any recent symptoms of: (Mark with an "X")

	Denies	Admits
HENT: Headaches		
Hearing loss		
Ear ringing		
Ear pain		
Nose bleeds		
Congestion		
Eyes: Blurred vision		
Double vision		
Eye pain		
Macular degeneration		

	Denies	Admits
Cardiac: Chest pain		
Palpitations		
Leg swelling		
Hematologic: Anemia		
Bruising		
Bleeding		
Respiratory: Cough		
Sputum production		
Shortness of breath		

Glaucoma		
Cataracts		
Eye discharge		
Eye redness		

Wheezing		

	Denies	Admits
Gastrointestinal: Reflux/GERD		
Nausea		
Vomiting		
Abdominal pain		
Diarrhea		
Constipation		
Blood in stool		
Musculoskeletal: Muscle aches		
Neck pain		
Muscle spasms		
Back pain		
Joint pain		
Falls		
Arthritis		
Psychiatric: Depression		
Suicidal ideas		
Hallucinations		
Nervous/anxious		
Insomnia		
Memory loss		

	Denies	Admits
Genitourinary: Pain with urination		
Urgency		
Frequency		
Blood in urine		
Waking up to urinate		
Catheterization		
Hesitancy to void		
Endocrine: Hypo-thyroid		
Hyper-thyroid		
Diabetes		
Neurologic: Dizziness		
Tingling		
Tremor		
Sensory changes		
Localized weakness		
Seizures		
Fainting		
Balance difficulty		

Family Medical History:

	Alive/Dead	Cause of Death/Illnesses
Mother		
Father		
Sister(s)		
Brother(s)		
Maternal Grandmother		
Maternal Grandfather		

Circle if any known family history of:	**Multiple Sclerosis** **Rheumatoid arthritis** **Crohn's disease** **Hashimoto's thyroiditis**

Paternal Grandmother		
Paternal Grandfather		
Other:		

If used, with approximate dates of use, and reasons for stopping (if applicable)

Avonex	
Betaseron/Extavia	
Copaxone/Glatiramer acetate	
Rebif	
Plegridy	
Tysabri	
Gilenya	
Mayzent	
Zeposia	
Aubagio	
Tecfidera	
Vumerity	
Lemtrada	
Ocrevus	
Rituximab	
Zinbryta	
Mavenclad/Cladribine	
Novantrone/Mitoxantrone	
Ampyra/Dalfampridine	
IVIG	
Cytoxan/Cyclophosphamide	

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Patient Health Questionnaire (PHQ-9)

Name: _____ **Date:** _____

Over the last two weeks, how often have you been bothered by any of the following problems? Use an "X" to indicate your answers.

	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or hurting yourself in some way				

Total Score:

Interpretation of Total Score for Depression Severity:

- **1-4: Minimal depression**
- **5-9: Mild depression**
- **10-14: Moderate depression**
- **15-19: Moderately severe depression**
- **20-27: Severe depression**

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Patient Consent and Authorization Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I acknowledge receipt of notice of privacy and authorize you to use and disclose my protected health information to, and inclusive of:

Disclose the patient's personal health information, treatment, billing, and payment. Disclose the patient's diagnosis for related lab and diagnostic centers where treatment is rendered as requested by Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment and health operations, but that Tampa Neurology Associates, LLC is not required to agree to the restrictions. However, if Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP agree, you are then bound to comply with this restriction.

If I revoke this consent, Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP does not have to provide any further healthcare services to the patient.

My signature below indicates that I have been given the chance to review a current copy of the Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP Notice of Privacy Practices. This can be found at www.fcneurology.net or can be provided upon request. My signature indicates that I agree to follow Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP to use and disclose my personal health information to carry out treatment, payment and healthcare operations.

Print Patient Name: _____ **Relationship to Patient**: _____

Signature: _____ **Date**: _____

Financial Agreement/Assignment of Benefits:

I hereby authorize payment to be made directly to Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP of benefits due to me from my insurance company. The responsible parties agree to pay for all fees, services and treatment incurred by the patient. If there is a fee that is not covered by insurance, this is payable by the patient. The patient also agrees to pay for all deductibles, co-payments and non-covered services. After receipt of a statement, if payment is not received by the next billing cycle, it is subject to a monthly finance charge. If an account is referred to an outside agency for collection, the patient agrees to pay for all such action. An account will be referred to a collection service if no payment has been received within 90 days of service.

Signature: _____ **Date**: _____

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Name: _____ **Date of Birth:** _____ **Gender:** _____

Home Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **Phone Number:** _____ **Email:** _____

Employer: _____ **Address:** _____

Business Phone: _____

Emergency Contact Name: _____ **Relationship:** _____

Phone Number: _____

Primary Insurance:
Insurance Company: _____
Address: _____
City: _____ **State:** _____
Zip Code: _____
Policy Holder Name: _____
Subscriber Name: _____
Group Number: _____

Supplemental Insurance:
Insurance Company: _____
Address: _____
City: _____ **State:** _____
Zip Code: _____
Policy Holder Name: _____
Subscriber Name: _____
Group Number: _____

Workmen's Compensation: Were you injured on the job? Yes ____ No ____ Date:_____

Employer: _____ **Insurance Company Responsible for Claim:** _____

Adjustor's Name: _____ **Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Public Liability: Is this the result of an accident? Yes ____ No ____ Date:_____

Attorney's Name: _____ **Phone Number:** _____

Insurance Company Responsible for Claim: _____

Name of Insured: _____ **Address of Insurance Company:** _____

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