WMC Health | Bon Secours Medical Group
Westchester Medical Center Health Network

Neurology Intake Form

DATE: _____/_____/_____

NAME:_____ D.O.B _____/_____/_____

BEST PHONE NUMBER TO REACH YOU:_____

REFFERING DOCTOR: _____
PRIMARY DOCTOR: _____
REASON FOR VISIT: _____

Circle: RIGHT HANDED LEFT HANDED BOTH

KNOWN MEDICAL CONDITIONS:

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

SURGERIES:

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

DRUG ALLERGIES: _____|_____ Reaction:_____|_____

Smoking: ☐Never ☐Currently ☐Former ☐Smokeless Tobacco Years Smoked ___ Packs per day___
Drink Alcohol: Y N **Use Illicit Drugs**: Y N **Exercise**: Y N **Pregnant**: Y N
Working: ☐Currently employed ☐ Not employed **Height:** ____'____ **Weight:** _____

NEUROLOGICAL DISEASES IN FAMILY? Y N : _____

MEDICATIONS: (don't include vitamins & supplements) (new patients or new from last visit)

Name	Dose	Times per day

WMC Health | Bon Secours Medical Group

NAME:_____ DATE: _____/_____/_____

CIRCLE ANY SYMPTOMS YOU ARE **CURRENTLY** EXPERIENCING

Check Here ___ if none

Constitutional	Eyes	Gastrointestinal	Endo/Heme/Allergies
Fever	Blurred Vision	Heartburn	Easy Bruising
Chills	Double Vision	Nausea	Allergies
Weight Loss	Bothered by Light	Vomiting	Increased Thirst
Fatigue/Malaise	Eye Pain	Abdominal Pain	Neurological
Sweating	Eye Discharge	Diarrhea	Dizziness
Weakness	Red Eyes	Constipation	Tingling
Skin	Heart and Vessels	Blood in Stool	Tremors/Shakes
Rash	Chest Pain	Rectal Bleeding	Loss of Sensation
Itching	Palpitations	Urinary	Change in Speech
HEENT	Short of Breath Lying Flat	Painful Urination	Weakness in a Limb
Headaches	Pain in Legs Walking	Urgent Urination	Seizures
Hearing Loss	Leg Swelling	Frequent Urination	Loss of Consciousness
Ear Pain	Short of Breath at Night	Blood in Urine	Psychiatric
Ear Discharge	Respiratory	Flank Pain	Depression
Nosebleeds	Cough	Musculoskeletal	Suicidal Thoughts
Congestion	Bloody Sputum	Muscle Aches	Substance Abuse
Breathing Sounds	Excess sputum	Neck Pain	Hallucinations
Sore Throat	Shortness of Breath	Low Back Pain	Nervous/Anxious
	Wheezing	Joint Pain	Insomnia
		Falls/Imbalance	Memory Loss

WMC Health | Bon Secours Medical Group
Westchester Medical Center Health Network

Registration

DATE: _____/_____/_____

Last Name_____ First Name_____ MI _____

D.O.B _____/_____/_____ Sex: ☐ Male ☐ Female SSN: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Other Pacific Islander

Ethnicity ☐ Hispanic ☐ Non-Hispanic Language _____

Mailing Address_____

Home Phone _____ Mobile Phone_____

Email Address_____@_____ ☐ None ☐ Decline

Employed ☐ Employer_____Occupation_____

Student ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disabled

Emergency Contact: _____Relationship_____

Emergency Phone: _____

Please check as they apply to you. If you have any questions please speak with your Provider.

Do you have? ☐ **Health Care Proxy** ☐ **Advanced Directive** ☐ **Durable Power of Attorney**

Can you provide a copy ☐ Yes ☐ No

Name of Legal Guardian or Health care proxy_____

Relationship to patient: _____Phone: _____

Primary caregiver: provides day to day care for patient and receives instructions about care ☐ None ☐ Yes

Caregiver Name_____

Relationship to patient _____

Turn over to continue on back page

WMC Health | Bon Secours Medical Group

Westchester Medical Center Health Network

INSURANCE INFORMATION

NAME:_____ DATE: _____/_____/_____

D.O.B _____/_____/_____

WORKERS COMP/NO FAULT: Is this visit under workers comp/no faults? YES _____ NO _____

Insurance carrier: _____

Claim address: _____

Claim Number: _____

Date of injury: _____

State of which the injury occurred: _____

Injured body part: _____

Claim adjuster's name & telephone number: _____

PLEASE GIVE INSURANCE CARD TO RECEPTIONIST

Primary Ins. Plan Name_____ Ins. Phone_____

Policy I.D_____ Group# _____

Policy Effective Date _____ Relationship to Policy Holder_____

Policy Holder Name_____ Policy Holder D.O.B_____

Policy Holder Address_____ ☐ Same as patient

Policy Holder SSN: _____-_____-_____

Secondary Ins. Plan Name_____ Ins.Phone_____

Policy I.D_____ Group# _____

Policy Effective Date _____ Relationship to Policy Holder_____

Policy Holder Name_____ Policy Holder D.O.B_____

Policy Holder Address_____ ☐ Same as patient

Policy Holder SSN: _____-_____-_____

WMC Health | Bon Secours Medical Group
Westchester Medical Center Health Network

Practice Communication and Personal Health Information (PHI) Form

By completing this form you will be granting Bon Secours Medical Group permission to release your Protected Health Information (PHI) to one or more personal representatives and/or to communicate with you in certain ways. Only the information indicated below will be released to your personal representative and/or communicated to you in the manner specified. This authorization is valid for one year from the date signed and will be renewed by the practice on a yearly basis. If at any time you would like to modify or revoke this permission you may do so by contacting the practice.

Patient Name: _____ Patient DOB: _____

Home Phone_____ Mobile Phone _____ Work Phone _____

Patient Address: _____

I request and authorize Bon Secours Medical Group to disclose and/or release my protected health information (PHI) to:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____

This authorization applies to :(check all that apply)

___ Healthcare Information

___ Demographic Information

___ Mental Health Information

___ HIV Information

___ Alcohol/Drug Treatment Information

___ Financial Information

___ Other Information Please Specify

_____

_____

_____

I hereby authorize Bon Secours Medical Group to:

Leave a message on my [ ] home [ ] business [ ] cellular telephone answering machine/voicemail, this message may contain my protected health information (PHI).

I also authorized Bon Secours Medical Group to contact _____ at the following number _____ in case of an emergency or to contact me regarding urgent medical issues.

I have carefully read and understand the above authorization. This authorization applies to all medical offices within the Bon Secours Medical Group, unless otherwise specified. I also understand that this authorization may be revoked at any time by contacting the practice administrator.

Printed Patient Name: _____

Patient Signature: _____

Authorization Date: _____ Expiration Date: _____
(One year after authorization date)