MEDICAL ASSOCIATES OF BREVARD

PATIENT INFORMATION

PATIENT'S NAME_____ ☐ MALE ☐ FEMALE
(LAST) (FIRST) (MI) (NICKNAME)

DOB ____/____/_____ SOCIAL SECURITY #_____-_____-_____ MARITAL STATUS: Single___ Married___ Other___

ADDRESS _____
(STREET) (CITY, STATE) (ZIP CODE)

HOME PHONE (_____) _____-_____ CELL PHONE (_____) _____-_____ WORK PHONE (_____) _____-_____

EMAIL ADDRESS_____@_____

PHARMACY NAME_____LOCATION_____

EMPLOYER _____ OCCUPATION_____

NAME OF SPOUSE OR PARENT _____ **EMERGENCY CONTACT INFORMATION:**

ADDRESS _____ NAME_____

_____ RELATIONSHIP_____ PHONE #_____

_____

REFERRING PHYSICIAN_____ FAMILY DOCTOR_____ PHONE # (____) _____-_____

INSURANCE INFORMATION – PRIMARY

INSURANCE CO. _____ POLICY # _____

POLICY HOLDER NAME_____ DOB ___/___/_____ S.S. # _____-_____-_____

INSURANCE INFORMATION - SECONDARY

INSURANCE CO. _____ POLICY # _____

POLICY HOLDER NAME_____ DOB ___/___/_____ S.S. # _____-_____-_____

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of pocket, deductibles and non covered services. I authorize the payments from my insurance company(s) according to my medical benefits be made payable to Medical Associates of Brevard for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

SIGNED _____ DATE _____/_____/_____

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MEDICAL ASSOCIATES OF BREVARD

HIPAA RELEASE

I authorize Medical Associates of Brevard to discuss my health care information with:

(Name)	(Relationship)	(Phone #)
(Name)	(Relationship)	(Phone #)

SIGNED _____ **DATE** _____/_____/_____

I authorize Medical Associates of Brevard to leave a detailed message on my answering machine.

SIGNED _____ **DATE** _____/_____/_____

Notice of Privacy Practices

I acknowledge that I have received a copy of the Provider Notice of Privacy Practices for Medical Associates of Brevard. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

_____

Print Name of Patient or Personal Representative

_____

Signature of Patient or Personal Representative Date

_____

Signature of Witness Date

PATIENT NAME _____

DATE OF BIRTH _____

Ronald A. Turck Jr., M.D.

Board Certified in Neurology

REVIEW OF SYSTEMS

PLEASE CHECK YES OR NO IF IT APPLIES TO YOU

GENERAL	YES	NO
FATIGUE	☐	☐
FEVERS	☐	☐
CHILLS	☐	☐
SWEATS	☐	☐
ANOXERIA	☐	☐
WEIGHTLOSS	☐	☐
MALAISE	☐	☐

HEM/ONC	YES	NO
HEMOPHILLIA	☐	☐
BLEEDING TENDENCY	☐	☐
BRUISE EASILY	☐	☐
BLOOD CLOTS	☐	☐
WEIGHT LOSS	☐	☐

ENDOCRINOLOGY	YES	NO
COLD INTOLERANCE	☐	☐
HEAT INTOLERANCE	☐	☐
POLYDIPSIA	☐	☐
POLYPHAGIA	☐	☐
POLYURIA	☐	☐
WEIGHT CHANGES	☐	☐

GENITOURINARY	YES	NO
URINARY FREQUENCY	☐	☐
DISCHARGE	☐	☐
DYSURIA	☐	☐
HEMATURIA	☐	☐
URINARY INCONTINENCE	☐	☐

MUSCULOSKELETAL	YES	NO
JOINT PAIN	☐	☐
SWELLING	☐	☐
STIFFNESS	☐	☐
BACK PAIN	☐	☐
RECENT INJURY	☐	☐

GASTROENTEROLOGY	YES	NO
NAUSEA	☐	☐
VOMITING	☐	☐
DIARRHEA	☐	☐
CONSTIPATION	☐	☐
ABDOMINAL PAIN	☐	☐

RESPIRATORY	YES	NO
COUGH	☐	☐
DYSPNEA	☐	☐
EXCESSIVE SPUTUM	☐	☐
HEMOPTYSIS	☐	☐
WHEEZING	☐	☐
SHORTNESS OF BREATH	☐	☐

CARDIOVASCULAR	YES	NO
CHEST PAIN	☐	☐
PALPITATIONS	☐	☐
SYNCOPE	☐	☐
DYSPNEA ON EXERTION	☐	☐
ORTHOPNEA	☐	☐
PERIPHERAL EDEMA	☐	☐

EAR/NOSE/THROAT	YES	NO
EAR PAIN	☐	☐
EAR DISCHARGE	☐	☐
TINNITUS	☐	☐
DECREASED HEARING	☐	☐
NASAL OBSTRUCTION	☐	☐
NASAL DISCHARGE	☐	☐
NOSEBLEEDS	☐	☐
SORE THROAT	☐	☐
HOARSENESS	☐	☐
DYSPHAGIA	☐	☐

CONTINUED ON BACK

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REVIEW OF SYSTEMS

PLEASE CHECK YES OR NO IF IT APPLIES TO YOU

NEUROLOGY	YES	NO
HEADACHE	☐	☐
POOR BALANCE	☐	☐
TINGLING/NUMBNESS	☐	☐
SEIZURES	☐	☐
TREMOR	☐	☐
MIGRAINES	☐	☐
VERTIGO	☐	☐
SCIATICA	☐	☐
LANCINATING PAINS IN FEET	☐	☐
BURNING PAIN IN HANDS	☐	☐
BURNING PAIN IN FEET	☐	☐
LOSS OF FEELIN/POWER	☐	☐
LOSS OF CONSCIOUSNESS	☐	☐
CONFUSION	☐	☐
PARALYSIS	☐	☐
WEAKNESS	☐	☐
INSOMNIA	☐	☐
SPEECH ABNORMALITY	☐	☐
VISUAL CHANGES	☐	☐
DIZZINESS	☐	☐
MEMORY LOSS	☐	☐
GAIT ABNORMALITY	☐	☐
SLEEP PROBLEMS	☐	☐

PSYCHOLOGY	YES	NO
DEPRESSION	☐	☐
STRESSORS	☐	☐
SLEEP DISTURBANCES	☐	☐
CONFUSION	☐	☐
MOOD SWINGS	☐	☐
ANXIETY	☐	☐
MANIA	☐	☐
SUICIDAL IDEATION	☐	☐
PARANOIA	☐	☐
HALLUCINATIONS	☐	☐
MENTAL OR PHYSICAL ABUSE	☐	☐
EATING DISORDER	☐	☐

PATIENT SIGNATURE _____ **DATE** _____

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HISTORY INTAKE FORM

Patient Name: _____ DOB: _____

PAST SURGICAL HISTORY

Please list **all** of your previous surgeries, including minor surgeries, along with the year and surgeon who did the operation.

1._____

2. _____

3. _____

4. _____

5. _____

PAST MEDICAL HISTORY

Please list **all** of your medical problems, including heart, lung, kidney problems, diabetes, cancer, high blood pressure, etc.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

MEDICATIONS

Please list **all** of your medication you are taking, including over –the-counter medicines such as aspirin, etc., along with the dose and frequency of the medication **(Bring medicine bottle to every appointment).**

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

ALLERGIES

Please list **all** of your allergies to medication and reaction you have with the medicine.

1._____ 3._____

2._____ 4._____

Continued on Back

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HISTORY INTAKE FORM *(cont'd)*

SOCIAL HISTORY

Circle One: Right handed or Left handed

Do you smoke? _____ If so, how long and how much? _____

If you were a previous smoker, when did you stop smoking? _____

Do you drink alcohol? _____ If so, how much and how frequent? _____

If you drank alcohol previously, when did you stop and how long did you drink? _____

Do you now or have you ever used any illegal drugs? _____

FAMILY HISTORY

Is your mother alive? _____ If not, of what and at what age did she die?_____

Is your father alive? _____ If not, of what and at what age did he die?_____

How many brothers _____ and sisters _____ do you have?

If not healthy, what disease so they suffer? _____

Please list their medical problems: _____

_____

Has anyone in your family suffered cancer or a neurological disease? Please list:

_____

_____

Patient Signature _____ Date: _____