



New Patient Registration

Patient Information

Patient Name

First _____ MI _____ Last _____

DOB ____/____/____ SS# _____

Marital Status _____ ☐ MALE ☐ FEMALE

Address _____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Occupation _____

Name of Spouse _____

Address: _____

☐ Check if same as patient's address

Race

☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian ☐ Black or African American ☐ White
☐ Other Pacific Islander ☐ Prefer not to answer

Ethnicity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino
☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ French ☐ Indian (includes Hindu & Tamil) ☐ Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone _____

Insurance Information

Primary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ____/____/____ SS# _____

Secondary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ____/____/____ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB ____/____/____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

☐ Check if same as patient's address

Employer _____

Mother's Name (or Guardian) _____

DOB ____/____/____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

☐ Check if same as patient's address

Employer _____



New Patient Registration

HIPAA Release

Patient Name

 First MI Last

Emergency Contact:

 Name

 Relationship

 Phone #

Do you have a Living Will? ☐ Yes ☐ No

Do you have an Advance Directive? ☐ Yes ☐ No

If you answered yes to either, please provide us a copy.

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

 Name

 Relationship

 Phone #

 Name

 Relationship

 Phone #

Preferred appointment reminder notification:

☐ Home Phone ☐ Cell ☐ Cell Text ☐ Work phone

☐ Mail ☐ E-Mail ☐ None

☐ With the person(s) authorized above

Preferred medical information notification:

I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:

☐ Home Phone ☐ Cell ☐ Cell Text ☐ Work phone

☐ Mail ☐ E-Mail ☐ None

☐ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.



Ronald A. Turck Jr., M.D.
Board Certified in
Neurology

HISTORY INTAKE FORM

Patient Name: _____

DOB: _____

PAST SURGICAL HISTORY

Please list **ALL** of your previous surgeries :

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

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 or a current list**).

- | | |
|----------|----------|
| 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



Ronald A. Turck Jr., M.D.
Board Certified in
Neurology

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 use any illegal drugs? _____ If yes, please list _____

Have you ever used illegal drugs? _____ If yes, please list _____

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?

How many children? _____ Are they healthy? _____

If not healthy, what disease so they suffer? _____

Please list their medical problems: _____

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

Patient Signature _____

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	GASTROENTEROLOGY		YES	NO
FATIGUE		☐	☐	NAUSEA		☐	☐
FEVERS		☐	☐	VOMITING		☐	☐
CHILLS		☐	☐	DIARRHEA		☐	☐
SWEATS		☐	☐	CONSTIPATION		☐	☐
ANOXERIA		☐	☐	ABDOMINAL PAIN		☐	☐
MALAISE		☐	☐				
INSOMNIA		☐	☐				
				RESPIRATORY			
HEM/ONC		YES	NO	COUGH		☐	☐
HEMOPHILLIA		☐	☐	DIFFICULT BREATHING		☐	☐
BLEEDING TENDENCY		☐	☐	EXCESSIVE SPUTUM		☐	☐
BRUISE EASILY		☐	☐	BLOOD IN SPUTUM		☐	☐
BLOOD CLOTS		☐	☐	WHEEZING		☐	☐
WEIGHT LOSS		☐	☐	SHORTNESS OF BREATH		☐	☐
ENDOCRINOLOGY		YES	NO	CARDIOVASCULAR		YES	NO
COLD INTOLERANCE		☐	☐	CHEST PAIN		☐	☐
HEAT INTOLERANCE		☐	☐	PALPITATIONS		☐	☐
ABNORMAL THIRST		☐	☐	FAINTING OR PASSING OUT		☐	☐
INCREASED APPETITE		☐	☐	LABORED BREATHING		☐	☐
EXCESSIVE URINATION		☐	☐	SHORT OF BREATH WHEN FLAT		☐	☐
WEIGHT CHANGES		☐	☐	PERIPHERAL EDEMA		☐	☐
GENITOURINARY		YES	NO	EAR/NOSE/THROAT		YES	NO
URINARY FREQUENCY		☐	☐	EAR PAIN		☐	☐
DISCHARGE		☐	☐	EAR DISCHARGE		☐	☐
DISCOMFORT WHEN URINATING		☐	☐	TINNITUS		☐	☐
BLOOD IN URINE		☐	☐	DECREASED HEARING		☐	☐
URINARY INCONTINENCE		☐	☐	NASAL OBSTRUCTION		☐	☐
MUSCULOSKELETAL		YES	NO	NASAL DISCHARGE		☐	☐
JOINT PAIN		☐	☐	NOSEBLEEDS		☐	☐
SWELLING		☐	☐	SORE THROAT		☐	☐
STIFFNESS		☐	☐	HOARSENESS		☐	☐
BACK PAIN		☐	☐	DIFFICULT TO SWALLOW		☐	☐
NECK PAIN		☐	☐				
SCIATICA		☐	☐				

CONTINUED ON BACK

REVIEW OF SYSTEMS

PLEASE CHECK YES OR NO IF IT APPLIES TO YOU

NEUROLOGY

	YES
HEADACHE	☐
POOR BALANCE	☐
TINGLING/NUMBNESS	☐
SEIZURES	☐
TREMOR	☐
MIGRAINES	☐
VERTIGO	☐
STABBING PAIN IN FEET	☐
BURNING PAIN IN HANDS	☐
BURNING PAIN IN FEET	☐
LOSS OF FEELIN/POWER	☐
LOSS OF CONSCIOUSNESS	☐
CONFUSION	☐
PARALYSIS	☐
WEAKNESS	☐
SPEECH ABNORMALITY	☐
VISUAL CHANGES	☐
DIZZINESS	☐
MEMORY LOSS	☐
GAIT ABNORMALITY	☐

NO

☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐

PSYCHOLOGY

	YES
DEPRESSION	☐
STRESSORS	☐
SLEEP DISTURBANCES	☐
CONFUSION	☐
MOOD SWINGS	☐
ANXIETY	☐
MANIA	☐
PARANOIA	☐
HALLUCINATIONS	☐
MENTAL OR PHYSICAL ABUSE	☐
EATING DISORDER	☐

YES

NO

☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐

PATIENT SIGNATURE

DATE



A Multi-Specialty Group Practice

Ronald A. Turck Jr., M.D.
Board Certified in Neurology
Fellowship Trained in Clinical Neurophysiology

Dr. Turck Appointment Cancellation and No-Show Policy

We understand that situations may arise requiring you to cancel or reschedule your appointment. If you must change your appointment, we request that you provide more than 24 hours' notice. This allows another patient who is waiting for an appointment to be seen.

- **Late Cancellations/Rescheduling:**
Appointments canceled or rescheduled with less than 24 hours' notice will be subject to a \$50.00 cancellation fee.
- **No-Shows:**
Patients who do not show up for their appointment or fail to confirm the day before will be considered a no-show and will be subject to a \$50.00 no-show fee. Patients who no-show two (2) or more times within a 12-month period may be discharged from the practice and denied future appointments.
- **Payment Responsibility:**
All late cancellation, late rescheduling, no-confirmation, and no-show fees are the sole responsibility of the patient and must be paid in full prior to your next appointment.

Our practice believes that a strong physician-patient relationship is built on understanding and good communication. Questions regarding late cancellation, rescheduling, or no-show fees should be directed to the Office Manager at (321) 241-6535.

By signing below, you acknowledge that you have read, understand, and agree to this policy.

Patient Signature

Date

Print Name

Date of Birth