Department of Neurology

736 Cambridge Street, Brighton, MA 02135-2997

David Weinberg, M. D.

NAME: _____Soc Sec #: _____
Last First MI

Address: _____ Apt #: _____
Street

City: _____State: _____ Zip Code: _____

Home Phone #: _____Work Phone #: _____Cell #:_____

Date of Birth: _____/_____/_____ Email: _____

Emergency Contact:
Name: _____Relationship to patient: _____
Daytime Phone #: _____ Evening Phone #: _____

Primary Care Physician: (Full Name) _____
Address: _____Phone #:_____

How were you referred to us? ☐ PCP ☐ Neurologist ☐ Friend ☐ Other: _____

Referring Physician: (Full Name) _____
Address: _____Phone #:_____

Insurance Information:

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Name of Insurance: _____	Name of Insurance:_____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____

Medical Information and Payment Authorization:

I request that payment of authorized medical benefit be made on my behalf to _____for services rendered. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents, or other insurer, any information to determine these benefits payable for related services.

Date: _____ Signature: _____

St. Elizabeth's Neurology Department

736 Cambridge St
Brighton MA 02135

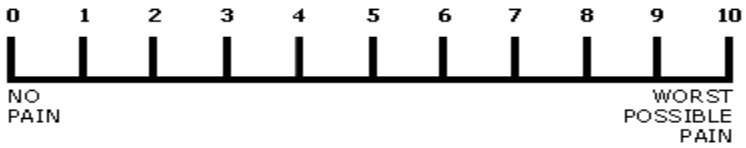
PATIENT QUESTIONNAIRE

Name:	*DOB: / /*	*Date: / /*

GENERAL	**Y**	**N**	***EXPLAIN BELOW***		**Y**	**N**	***EXPLAIN BELOW***
Skin Problems/Rash				**GI**			
Anemia				Nausea/Vomiting			
Fever/Chills				Diarrhea/Constipation			
Night Sweats				Bloody or black stool			
EYES/EARS				Heart Burn			
Visual Changes				Weight Loss/Gain			
Hearing Changes				Abdominal Pain			
NOSE/THROAT				**NEUROLOGIC**			
Hoarseness				Convulsions/Seizures			
Trouble Swallowing				Headache			
Gland Swelling				Dizziness/Passing Out			
RESPIRATORY				Shaking/Tremors			
Cough				Muscle Weakness/Fatigue			
Shortness of Breath				Tingling/Numbness			
Wheezing				Loss of Feeling			
Sputum Production				Back Pain			
UROLOGIC				**MOOD/SLEEP**			
Pain/Frequent Urination				Nervousness/Anxiety			
Blood in Urine				Depression			
Trouble Urinating				Sleep Disorder/Fatigue			
Urinary Incontinence				**PSYCH-COGINTION**			
CARDIOVASCULAR				Hallucinations			
Chest Pain				Paranoid Feelings			
Leg/Back pain walking				Memory Loss			
Ankle Swelling							
Fast Heart Beat/Murmur							

Height _____ **Weight**_____

Please rate your pain on the following scale:



Name:	*DOB: / /*	*Date: / /*

Do you smoke now or did you ever smoke? Yes No
If yes, how many packs a day? For how long? When did you quit?

Do you drink alcohol? Yes No
If yes, how may drinks per week?

Do you now or did you every have a problem with alcohol or drug use/

Do you have an Advanced Care Plan? Yes No or Surrogate decision maker? Yes No

What medications are you currently taking? (Prescription, OTC, Herbals, Vitamins, Supplements)

Medications Dose Frequency How Taken (by mouth, injection, other)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please circle any anti-inflammatory medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

Advil Arthrotec Daypro Ibuprofen Lodine Naprelan Naproxen

Oruvail Tylenol Ultram Other: _____

Please circle any of the following side effects while you were currently taking any of the above anti-inflammatory medications.

Nausea Diarrhea Gastric Ulcers Upset stomach Vomiting

Other: _____

Are you currently taking any of the following on a regular basis?

Aspirin Axid Coumadin Cytotec Heparin Maalox Mylanta

Pepcid Prevacid Prilosec Tagamet Zantac

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION CAN BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

MEMBER ORGANIZATIONS: This notice applies to the Department of Neurology, including their physicians, nurses and other personnel.

As of April 14, 2003, we are required under the Health Insurance Portability and Accountability Act (HIPPA) and currently under Massachusetts law to maintain the privacy of your health information and to provide you with this Notice of Privacy Rights & Practices.

This document explains in detail how we use your Protected Health Information (PHI) which is any information about you that could identify you, your past, present or future physical or mental health condition (s). Your acknowledgement of receipt of this document will be required the first time you receive services after June 26, 2003 in the Neurology Department at St. Elizabeth's Medical Center.

Examples of how we can use and disclose your information without your authorization include:

Treatment - we keep a record of each visit and or admission. These records may include your test results, diagnoses, medications or other therapies. These records are used and disclosed to allow doctors, nurses, spiritual care and other health care clinical staff providers to offer high quality care to meet your needs.

Treatment - we maintain a record of and may use and disclose information related to, services and supplies you receive at each visit or admission, so that we can be paid by you, an insurance company, or a third party. We may tell your health plan and other payers about an upcoming treatment or service, which requires their prior approval and authorization.

Health Care Operations – we use and disclose your medical information to improve the services we provide, to train staff and students, for business management and for customer services purposes.

Information may be shared amongst Health Care organizations, other health care providers, third party payers and our business associates to facilitate treatment, payment or health care operations.

Additional Uses & Disclosures

There are additional times when we are permitted or required to use/disclose medical information without your permission.

- Emergency treatment situations
- To assist incommunicative patients or communicate with those involved in your care
- Reporting child/elder/disabled persons abuse or neglect
- Organ donations
- Workers Compensation if you are injured at work
- Coroners, medical examiners and funeral directors
- Correctional Institution
- Report a serious threat to public safety
- If required by law
- For law enforcement
- For Public health activities (tracking disease or medical devices)
- For health oversight activities such as fraud investigations
- For certain judicial or administrative proceedings
- For government functions such as national security & intelligence
- For research following an appropriate review or waiver of authorization by an institutional review board to ensure protection of information

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Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____ (patient's name), have received a copy of Department of Neurology Notice of Privacy Practices.

_____

Signature of patient Date signed