Patient Personal History

Name: ________________________________Age_____ **Date of Birth**_____________

Address:____
(Street & Number) (City) (State) (Zip)

Home Phone_____________________Social Security Number_____________________
Office Phone__________________________Cell Phone__________________________

Allergies____
Current Medications____

Chief Complaint____

Date Symptoms Started____________Previous Similar Symptoms? Yes( ) _____No ( )
When?

Referred By?____

Primary Care Physician?____

IF TREATED BY ANOTHER PHYSICIAN FOR THIS PROBLEM (other than referring physician)

DATE_________NAME___________________ADDRESS__________________

Person Responsible for Bill

Name____________________________**Relationship to Patient**_______________________

Address____
(Street & Number) (City) (State) (Zip)

ARE YOU EMPLOYED? FULL TIME?_____________**PART TIME?**___________________

Employer Name:____

Employer's Address__________________________________Phone_____________________

Insurance Information__________________________________**Policy#**_________________

Policy Holder's Name: ____________________**DOB & SS#**____________________________

Policy Holder's Employer & Address____

Policy Holder's Insurance _____________________Policy#__________________________

ARE YOU A STUDENT? FULL TIME?______________**PART TIME?**___________________

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO NEUROLOGICAL SERVI CES OF ORLANDO PA.

SIGNATURE OF INSURED OR AUTHORIZED PERSON____

DATE _______________________________________