ADVENT NEUROLOGY, SC
Sailaja Maramreddy, MD
657 E Golf Rd Ste 304, Arlington Heights, IL 60005, Ph. 847.640.7377; Fax: 847.640.7977

NEW PATIENT FORM

DATE _____

NAME _____ Birth Date _____ Age_____

Requesting Physician _____ Phone # _____Fax#_____

Primary Care Physician_____Phone # _____Fax#_____

Reason for your visit today: _____

Social History Occupation: _____

Tobacco O nonsmoker O Former smoker, Quit month/year O Current smoker, How many/day?

Alcohol Yes No If yes, how much and how often?

Sex (*Circle one*) M F **Marital status** (*Circle one*) Single Married Divorced Separated Widowed

Race (Please circle): Asian Native Hawaiian/Pacific islander Black/African-American White Hispanic Other

Ethnicity (Please circle) Hispanic/Latino Not Hispanic or Latino

Drug/Food Allergies _____

Family Medical History

	Father	Mother	Siblings	Others (specify)
Alzheimer's				
Cancer (specify type of cancer)				
Diabetes I/II				
Heart attack				
Hypertension				
Mental illness				
Migraine				
Multiple Sclerosis				
Muscle disorder				
Parkinson's				
Seizure				
Stroke				
Other (Specify)				

Past Medical History **O Please check this box if there is no prior medical history**

O Anxiety	O Bleeding disorder	O Back pain or injury	O Cancer _____
O Diabetes	O Depression	O Gastric reflux disease	O High blood pressure
O Heart disease	O High Cholesterol	O Migraine/headaches	O Kidney disease
O Lung disease	O Liver disease	O Parkinson's	O Rheumatoid arthritis
O Sezure	O Stroke	O Thyroid disease	O Other_____

Prior Surgical History (List date of surgery in the space provided). If you had no surgeries, please check here **O None**

O Appendectomy _____	O Carotid artery surgery _____	O Carpal tunnel surgery _____
O Cranial surgery_____	O Heart bypass surgery _____	O Heart stents _____
O Knee surgery _____	O Low back surgery _____	O Neck surgery_____
O Thyroid surgery_____	O Other_____	O Other_____

Name_____ DOB_____ Today's date_____

Review of Systems

Check (✔) if you had any of the following during the past **three months**?

CONSTITUTIONAL		*GASTROINTESTINAL*		*NEUROLOGICAL*	
Fatigue		Blood in stool		Confusion	
Fever		Decreased appetite		Convulsions	
Headaches		Nausea		Black-outs or syncope	
EYES		Vomiting		Muscle twitching or cramps	
Blurred or double vision		HEMATOLOGIC/LYMPHATIC		Stroke	
ENT		Anemia		Head injury	
Hearing loss		Easy bruising		Balance difficulty	
Ringing in the ears		*GENITOURINARY*		Difficulty speaking	
ENDOCRINE		Difficulty urinating		Dizziness	
Cold intolerance		Frequent urination		Fainting	
Heat intolerance		Painful urination		Gait abnormality	
RESPIRATORY		Urinary incontinence		Frequent headaches	
Cough		*MUSCULOSKELETAL*		Tingling/numbness	
Shortness of breath at rest		Walking difficulty		Tremors	
Short. breath on exertion		Back pain		*PSYCHIATRIC*	
CARDIOVASCULAR		Neck pain		Memory loss or confusion	
Chest pain at rest		Muscle aches		Anxiety	
Chest pain on exertion		Painful joints		Depressed mood	
Irregular heartbeat		Weakness		Sleep problems	
		SKIN Rash			

Current Medications

Drug Name	Dosage	Start Date	Reason

Diagnostic studies

	CT	MRI	X-Ray	EEG	EMG
Date					
Type					
Location					

Hospital admissions:_____

_____

The undersigned hereby authorizes the physicians of the Advent Neurology to perform any diagnostic aids deemed necessary by the doctor to make thorough diagnosis of my needs. I also authorize the physicians of Advent Neurology to perform any and all forms of treatment, medical and therapy that may be indicated. I also give my consent to Advent Neurology to obtain medication information from external sources. All the information on this medical history form is correct and fully understood by me.

Name _____ Signature _____ Date _____

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REGISTRATION FORM

Date _____

PERSONAL INFORMATION

Patient's Name_____Birth Date:_____Age _____

Address: _____

Patient's Soc. Sec. Number_(Last 4 digits)__xxx-xx-_____ Email _____

Primary contact phone number _____ Alternative Number_____

Sex (*Circle one*) M F **Marital status** (*Circle one*) Single Married Divorced Separated Widowed

Emergency contact	Relationship	Phone number(s)

Occupation:_____ Employer: _____

Employer's Address: _____

INSURANCE (Please bring all insurance cards to the appointment)

Primary Insurance Company : _____Insurance co. phone_____

Insurance company address_____

Policy Holder's Name : _____Policy Holder's employer_____

Patient's relationship to Policy holder: _____Policy Number _____ Group ID_____

Secondary Insurance Co.:_____Insurance company phone_____

Insurance company address_____

Policy Holder's Name : _____Policy Holder's employer_____

Patient's relationship to Policy holder: _____Policy Number _____ Group ID_____

Pharmacy Name: _____ Address_____Ph._____

Acknowledgment of receipt of Notice of Privacy Practices of Advent Neurology, SC

This is to acknowledge the receipt of the Notice of Privacy Practices of Advent Neurology, SC.

Name _____Signature _____ Date _____

ASSIGNMENT & RELEASE: I hereby give lifetime authorization for payment of insurance benefits to be made directly to the physician for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

Name of guarantor _____Signature _____ Date _____

Communication Consent

Please check your preferred methods of communication (Please write the phone number. If no number is noted, we will use your primary/alternative numbers)

O Home phone _____ O Mobile phone _____ O Fax _____

O US Mail _____

I understand that the physicians and staff of Advent Neurology may contact me to discuss clinical information related to my care. I agree that the staff and the physicians of Advent Neurology may contact me via any of the methods of communication indicated above. If I do not answer the telephone, they may leave a message on my voice mail or answering machine. I agree that they may send a facsimile to the number listed above to convey information about test results, clarify medication dosages, or answer simple medical questions.

Name _____Signature _____ Date _____

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Name _____ Date of Birth_____

Current Medications

Drug Name	Dosage	Start Date	Reason

_____ _____

Signature Date