



Southwestern Institute of Neurology

929 N. Galloway Ave., Suite 102
Mesquite, TX 75149
Telephone: 972-329-8200
Fax: 972-329-8202

PATIENT INFORMATION

Please fill out all 5 pages

PATIENT NAME: _____ (LAST) (FIRST) (MI) ADDRESS _____ _____ CITY _____ STATE _____ ZIP _____ COUNTY _____ PHONE NO. _____ EMPLOYER NO. _____ ALT. NO. _____	REFERRING PHYSICIAN: _____ _____ PHONE NO. _____ SOCIAL SEC. NO. _____ DATE OF BIRTH: MO _____ DAY _____ YR _____ AGE _____ DL# _____ ST. _____ GENDER: MALE _____ FEMALE _____ MARITAL STATUS _____ PARENT NAME _____ (IF CHILD UNDER 17) FAMILY PHYSICIAN: _____ _____ PHONE: _____
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PERSON RESPONSIBLE FOR BILL

NAME _____ (LAST) (FIRST) (MI) ADDRESS _____ _____ CITY _____ STATE _____ ZIP _____ PHONE NO. _____ GENDER: MALE _____ FEMALE _____ RELATION TO PATIENT _____ _____	SOCIAL SEC. NO. _____ DATE OF BIRTH: MO _____ DAY _____ YR _____ EMPLOYER _____ EMPLOYER ADDRESS _____ _____ CITY _____ STATE _____ ZIP _____ EMPLOYER PHONE NO. _____ OCCUPATION: _____ FULL TIME _____ PART TIME _____
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EMERGENCY NOTIFICATION INFORMATION

PERSON TO NOTIFY: _____ _____ OK TO NOTIFY: YES _____ NO _____ HOME PHONE: _____ ALT. NO. _____	CAN MESSAGE BE LEFT WITH THIS PERSON? YES _____ NO _____ ADDRESS: _____ _____ CITY _____ STATE _____ ZIP _____
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INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ POLICY NO. _____ GROUP NO. _____ PHONE NO. _____ NAME OF INSURED _____ _____	SECONDARY INSURANCE COMPANY _____ POLICY NO. _____ GROUP NO. _____ PHONE NO. _____ NAME OF INSURED _____ _____
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AUTHORIZATION & RELEASE: I hereby authorize and direct my insurance benefits to be paid directly to the Physician. I also authorize the release of any information regarding medical records to the insurance companies. As parent/guardian of above patient, I consent to treatment of said patient. I understand I am financially responsible for any fee incurred; this includes fees for medical services not covered by my insurance.

SIGNATURE _____ **DATE** _____



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Authorization for Release of Medical Records

I, _____, authorize **SOUTHWESTERN INSTITUTE OF NEUROLOGY**
(Patient/Parent of Minor)
to release my medical records TO: (please list names of person you wish your records to be released to)

PCP/Referring Physician _____ Address _____
Phone _____ Self _____ Relatives _____
Other Parent/Guardian _____

PATIENT NAME _____ D/O/B _____ - _____ - _____
(PLEASE PRINT LEGIBLY) SOCIAL SEC NO. _____ - _____ - _____

I GIVE PERMISSION FOR SUCH INFORMATION TO BE RELEASED

_____ HISTORY & PHYSICAL
_____ CONSULTATION
_____ LABORATORY
_____ X-RAY
_____ IMMUNIZATIONS
_____ PROGRESS NOTES
_____ OTHER _____

PURPOSE FOR RELEASE OF INFORMATION:

_____ DOCTOR'S RELEASE
_____ INSURANCE
_____ PERSONAL
_____ OTHER _____

Authorization for Request of Medical Records

I, _____, authorize **SOUTHWESTERN INSTITUTE OF NEUROLOGY**
(Patient/Parent of Minor)
to request my medical records FROM: (please list names of person/facility you wish your records to be requested from)

PCP/Referring Physician _____ Phone _____
Hospital/Facility _____ Phone _____

I GIVE PERMISSION FOR SUCH INFORMATION TO BE REQUESTED

_____ HISTORY & PHYSICAL
_____ CONSULTATION
_____ LABORATORY
_____ X-RAY
_____ IMMUNIZATIONS
_____ PROGRESS NOTES
_____ OTHER _____

PATIENT'S SIGNATURE

DATE

PARENT/LEGAL GUARDIAN



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CONDITIONS OF TREATMENT

PATIENT'S NAME _____ SS# _____

PHYSICIAN _____ DATE & TIME _____
(Dr. to be seen here today)

I AM PRESENTING MYSELF FOR OFFICE VISIT AND I VOLUNTARILY CONSENT TO THE RENDERING OF SUCH CARE INCLUDING DIAGNOSTIC TESTS AND MEDICAL TREATMENT BY AN AUTHORIZED PHYSICIAN.

I UNDERSTAND THAT THE EXAMINATION AND TREATMENT THAT I RECEIVE IS NOT INTENDED AS A SUBSTITUTION OR REPLACEMENT FOR COMPLETE MEDICAL CARE.

I UNDERSTAND THAT I WILL RECEIVE A BILL FROM THE PHYSICIAN WHO PROVIDES PROFESSIONAL CARE TO ME.

I UNDERSTAND THAT I AM FINANCIALLY AND LEGALLY RESPONSIBLE FOR THE CHARGES NOT COVERED IN FULL BY ANY THIRD PARTY. I FURTHER AGREE THAT I SHOULD PAY COST OF COLLECTION INCLUDING REASONABLE ATTORNEY'S FEES AND COSTS, COLLECTION AGENCY FEES AND COSTS, AND INTEREST WHICH ACCRUE AT THE MAXIMUM RATE ALLOWED BY LAW.

I CERTIFY THAT I HAVE READ THE ABOVE CONDITIONS AND AGREE WITH THEM.

(PATIENT SIGNATURE or LEGALLY AUTHORIZED REP.)

(PRINT NAME OF PERSON ABOVE)

(DATE): (MONTH) (DAY) (YEAR)



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Cancellation of Appointments

I _____ understand that if I wish to reschedule or cancel my appointment, I am
Patient's Name
to notify Southwestern Institute of Neurology 48 hours prior to reschedule or cancellation. If I do not
call in time or do not show up for my appointment, there will be a charge of \$50 sent directly to me
and not to my insurance.

Patient's Signature

Date



Name _____ Date _____

MEDICAL HISTORY

1. Briefly explain the reason for this neurological evaluation. Why you are being seen.

2. Briefly give the list of medical problems you have been diagnosed with:

- | | | |
|-----------------------------------|-----|----|
| a. High blood pressure | Yes | No |
| b. Diabetes | Yes | No |
| c. Heart condition | Yes | No |
| d. Malignancies | Yes | No |
| e. Vision problem | Yes | No |
| f. Chest pain/shortness of breath | Yes | No |
| g. Leg cramps/leg pain/tired legs | Yes | No |
| h. Headaches | Yes | No |
| i. Seizure disorder | Yes | No |
| j. Fainting spells | Yes | No |
| k. Other _____ | | |

3. Surgery (Explain)

4. Has any blood relative ever had: cancer, diabetes, high blood pressure, circulation problems, heart disease, stroke, seizure disorder, headache, other?

- | | | | |
|------------------------|-----|----|-----------|
| 5. Do you use alcohol? | Yes | No | How much? |
| Tobacco | Yes | No | How much? |
| Recreational drugs | Yes | No | How much? |

6. Please list your medications: _____

7. Allergies to medication: _____

8. Recent labs, x-rays, MRI, CT scan (date and where done)
