FLORIDA NEUROHEALTH

Bruce R. Hoffen M.D., P.A.
515 West State Road 434 Suite 205
Longwood, Fl 32750

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ SSN: _____ SEX: M F

Address: _____ City: _____ Zip: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ E-mail Address_____

Employer's name/address/phone number:_____

Today's Date: _____ Date of Injury: _____ Are you: Right-handed Left-handed

Primary Care Physician:_____ Phone: _____

Did a physician send you to our office? ____ If 'yes' who is the referring physician? _____

Pharmacy Name: _____ Pharmacy Location/Phone number _____

INSURANCE INFORMATION

Insured's Name (if different from patient): _____ Relationship: _____ DOB_____

Employer Name: _____ Insured's Social Security #_____

Insurance /address/phone number: _____

Insurance I.D./policy number: _____ Group number: _____

Is this related to an Automobile Accident? _____ YES _____ NO

Claim Number: _____ Date of Accident (if applicable) _____

Adjuster name/phone: _____ Attorney Name/phone number: _____

Is this covered under Workers Compensation? _____ YES _____ NO

Claim Number: _____ Date of Accident (if applicable) _____

What the name/phone number of your adjuster? _____

HISTORY OF PRESENT ILLNESS:

Ht:_____'_____" Wt:_____lbs.

Chief complaint _____

SYMPTOMS

Location: _____
Where is the problem? Does it travel to other areas?

Severity: _____
How severe is the pain on a scale of 1-5 with 5 being the most sever?

Duration: _____
How long have you had this problem? When did it start?

Associated signs/symptoms: _____
Do you have numbness? Abnormal sounds: cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain?

Modifying factors: _____
What makes the problem worse or better? (Activities)

Internal Use Only

Vitals: Temp_____ HR_____ BP sys_____ dias_____ RR_____

Name _____

PAST MEDICAL HISTORY: Have you ever had any of the following? *Please circle all pertinent conditions*

Alzheimer's disease	Depression	HIV infection	Neuropathy	Ulcer
Anemia	Diabetes	Infectious Mono	Osteoarthritis	Venereal disease
Arthritis	Epilepsy/seizures	Kidney disease	Osteoporosis	Other _____
Asthma	Fibromyalgia	Leukemia	Parkinson's	_____
Back trouble	GERD	Low blood pressure	Pneumonia	_____
Breast cancer	Glaucoma	Low back pain	Polio	_____
Bladder infections	Heart disease	Lupus	Prostate cancer	_____
Bleeding disorders	Hemorrhoids	Macular degeneration	Sleep apnea	
Blood transfusions	Hepatitis	Measles	Stroke	
Bronchitis	High blood pressure	Mitral valve prolapse	Thyroid disease	
Chicken pox	High cholesterol	Multiple sclerosis	Tuberculosis	

Please list all medications you are taking: Include non-prescription and herbal supplements

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Are you allergic to any medications?

Medication	Reaction			
_____		Tape Allergy:	Yes	No
_____		Latex Allergy:	Yes	No

Past surgical/hospitalization History:

Date	Surgery/Illness	Doctor	Hospital, City, State
_____			
_____			
_____			
_____			
_____			

Name: _____

Patient Social History**:**

Marital status	**Use of alcohol**	**Use of Tobacco**	**Living Situation**
Single	Never	Never	With Family
Married	Rarely	Previously, but quit	With Friends
Widowed	Moderate	Currently	Alone
Separated	Daily	___ packs per day	other
Divorced			_____

Family Medical History:

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below: (Please circle all that apply.)

Musculoskeletal

Joint pain	no	yes
Joint stiffness/swelling	no	yes
Weakness of muscles/joint	no	yes
Muscle pain/cramps	no	yes
Back pain	no	yes
Cold extremities	no	yes
Difficulties walking	no	yes

Constitutional Symptoms

Recent weight changes	no	yes
Fever	no	yes
Headaches	no	yes
Fatigue	no	yes

Ear/Nose/Mouth/Throat

Hearing loss/ringing	no	yes
Earaches or drainage	no	yes
Chronic sinus problems	no	yes
Nose bleeds	no	yes
Bleeding gums	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes

Cardiovascular

Chest pain or angina	no	yes
Palpitation	no	yes
Shortness of breath While walking	no	yes
Swelling feet, ankles Or hands	no	yes

Genitourinary

Frequent Urination	no	yes
burning/painful urination	no	yes
blood in urine	no	yes
incontinence of dribbling	no	yes
f-number of pregnancies	_____	
f-number of deliveries	_____	

Integument (skin/breast)

rash or itching	no	yes
changes in skin color	no	yes
varicose veins	no	yes
breast pain	no	yes
breast lump	no	yes

Neurological

light headed or dizzy	no	yes
numbness/tingle sensation	no	yes
tremors	no	yes
weakness	no	yes
memory loss	no	yes
speech difficulties	no	yes

Endocrine

excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
skin becoming dryer	no	yes

Hematological/Lymphatic

slow to heal after cuts	no	yes
bleeding/bruising tendency	no	yes
anemia	no	yes
enlarged glands	no	yes

Psychiatric

nervousness	no	yes
depression	no	yes
insomnia	no	yes

Gastrointestinal

loss of appetite	no	yes
nausea of vomiting	no	yes
frequent diarrhea	no	yes
constipation	no	yes
rectal bleeding/blood in stool	no	yes
abdominal pain	no	yes

Respiratory

Chronic of frequent coughs	no	yes
spitting up blood	no	yes
shortness of breath	no	yes
wheezing	no	yes

Eyes

eye disease or injury	no	yes
wear glasses/contact lens	no	yes
blurred or double vision	no	yes

Allergic/Immunologic

List food/environment allergies:

_____
_____
_____
_____
_____
_____

Medications

_____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary, services I may need.

_____ _____

Signature of Patient Date

Bruce R. Hoffen, M.D., P.A. Neurology 515 W. SR 434 Suite 205 Longwood, FL 32750

ASSIGNMENT OF INSURANCE BENEFITS

I/we assign payment directly to **BRUCE R. HOFFEN, M.D., P.A.** I understand that I am financially responsible for charges not paid by this assignment and that I will assist in the collection of my insurance should there be any delay in payment.

PAYMENT POLICY

1. I/we understand that payment is due **at the time of service**. Copayments, coinsurance and deductibles can be paid by cash, personal checks, MasterCard or Visa. There is a $25 fee for returned checks. Medicare patients are responsible for their deductibles and charges for non-covered services.

2. **BRUCE R. HOFFEN, M.D., P.A.** will file paperwork for secondary insurance if the correct information is supplied and deductibles have been met.

3. I/we understand that I am responsible for keeping my appointment. A $25 fee will be assessed for all cancellations with less than 24 hours notice or for failure to appear for appointments.

4. Failure to pay bills owed to **BRUCE R. HOFFEN, M.D., P.A**. may result in collection action. I/we understand that if my account is sent to collections, I will be held responsible for collection fees and/or attorney fees. If a bill is more than 30 days overdue, a $15 late fee will be charged.

5. **I/WE AM ULTIMATELY RESPONSIBLE FOR MY BILL**. If my insurance company has not paid within 45 days following treatment, I understand the entire balance becomes due.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Please sign below to acknowledge the information on this document.

_____ _____

Patient /Guarantor Signature Witness

_____ _____

Please Print Date

BRUCE R. HOFFEN, M.D., P.A.
AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information (" protected health information") and medical record information by **Bruce R. Hoffen, M.D., P.A.** (the "Practice") in order to carry out treatment, payment, or health care operations.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: _____

_____

I agree and consent to the Practice releasing information to me in the following alternative manners (please initial the appropriate spaces below):

_____ Via regular mail with any envelopes being marked personal and confidential and addressed to me.

_____ Via telephone, if I contact the Practice and provide the appropriate information (including my name, social security number and unique personal identifier).

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) does not sign this Consent Form. If you (or authorized representative) sign this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorize party to act on the behalf of the patient to sign this document verifying consent to the above terms.

_____ _____

Signature of Patient or authorized representative Printed Name & Date

- Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the Patient:

  _____

  _____