PLEASE COMPLETE IN FULL

PATIENT HISTORY

NAME: _____ DOB: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

REFERRING PHYSICIAN: _____

Are you right-handed or left-handed: _____

PAST HISTORY:

Have you ever been hospitalized? Yes/No Have you ever had surgery? Yes/No

List surgeries/year: _____

HAVE YOU EVER HAD:

		Yes	No			Yes	No
1)	Psychiatric problems	____	____	12)	Liver Disease	____	____
2)	High Blood Pressure	____	____	13)	Kidney Ailments	____	____
3)	Diabetes	____	____	14)	Arthritis/Rheumatism	____	____
4)	Heart Disease	____	____	15)	Skin Disorders	____	____
5)	Rheumatic Fever	____	____	16)	Blood Disorder	____	____
6)	Tuberculosis	____	____	17)	Thyroid Problems	____	____
7)	Bronchitis	____	____	18)	Visual Difficulties	____	____
8)	Emphysema	____	____	19)	Injuries	____	____
9)	Asthma	____	____	20)	Cancer	____	____
10)	Peptic Ulcers	____	____	21)	AIDS	____	____
11)	Diverticulosis	____	____	22)	Headaches	____	____

Do you have drug allergies? Please list: _____

Are you taking any medications? Please list: _____

_____

PERSONAL HISTORY:

Marital Status: _____ Occupation: _____

Children: _____ Alcohol: _____ Tobacco: _____

Emotional Stress: _____ Hobbies: _____

FAMILY ILLNESSES:

Father: _____ Mother: _____

Brothers: _____ Sisters: _____

Children: _____ Others: _____

CURRENT SYMPTOMS:

(x) yes - positive or abnormal ( ) no

GEN:	( ) fever	( ) chills	( ) weight loss	( ) weight gain	( ) fatigue
ENT:	( ) sore throat	( ) nasal congestion	( ) sinus infection	( ) hearing loss	( ) sinus allergies
EYES:	( ) pain	( ) redness	( ) itching	( ) tearing	( ) vision loss
RESP:	( ) cough	( ) expectoration	( ) shortness of breath	( ) wheezing	( ) cough blood
CVS:	( ) chest pain	( ) palpitation	( ) sleep propped up	( ) blackout	( ) foot swelling
GI:	( ) abdominal pain	( ) nausea	( ) vomiting	( ) heartburn	( ) diarrhea
GU:	( ) painful urination	( ) urgency/frequency	( ) urination at night	( ) blood in urine	( ) impotence
CNS:	( ) headache	( ) numbness	( ) tingling	( ) convulsions	( ) memory loss
MSK:	( ) back pain	( ) neck pain	( ) joint pain	( ) joint swelling	( ) muscle pain
MISC:	( ) depression	( ) anxiety	( ) sleep problems	( ) skin rash	( ) itching

Bacchus & Vaughan Neurology Associates, L.L.P.

602 Hickory, West Suite Abilene, TX 79601
Phone # (325) 704-5120 Fax # (325) 704-5123

IMPORTANT! Items in BOLD are required to process your claims. Failure to provide this information could lead to the denial of benefits.

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ MI: _____

Address: _____ Sex: Male Female

City: _____ **State:** _____ **Zip:** _____ Student: No Part Time Full Time

Social Security #: _____ **Date of Birth:** _____

Home Phone: _____ Cell Phone: _____

Referring Physician*: _____ *Doctor's First and Last Name Required

Work Related*: Yes No **If Yes, date of injury:** _____

*If work related, the following information **MUST** be completed to process your claim.

Employed: Full Time Part Time No Retired

Employer: _____ Drivers License #: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Work Phone:** _____

Position:

PRIMARY INSURANCE INFORMATION

Ins. Company: _____ **Ins. Phone Number:** _____

Ins. Claims Address: _____

Member ID #: _____ Effective Date: _____

Group Name: _____ Group ID #: _____

Type of Plan: _____ (i.e. HMO) Deductible: _____ Co-Pay: 10 15 20 25 35

Name of Insured: _____ **Insured's DOB:** _____

Insured's Address: _____

Relationship to Insured:

SECONDARY INSURANCE INFORMATION (if applicable)

Ins. Company: _____ Ins. Phone Number: _____

Ins. Claims Address: _____

Member ID #: _____ Effective Date: _____

Name of Insured: _____

Insured's DOB: Relationship to Insured:

In case of emergency notify: _____ **Phone:** _____

I understand that I am responsible for all charges incurred by me and all charges not allowed by my insurance company. I authorize release of any medical information necessary to process my claims. I authorize payment of any assigned benefits to Bacchus & Vaughan Neurology Associates, LLP. I understand that I am responsible for calling the office within 24 hours if I cannot keep my scheduled appt. **No Show Appointments may be charged!**

_____ _____

Signature Date

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

INFORMATION DISCLOSURE RELEASE

PATIENT'S NAME: _____

I give my permission for the staff at Bacchus & Vaughan Neurology Associates, LLP to disclose information regarding my medical condition and treatment with the following people:

_____ _____

_____ _____

_____ _____

_____ _____

I understand that disclosure to any other person or source will require additional authorization unless directly related to my treatment, payment, or operations.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority