HARTFORD NEUROLOGY, LLC

Please take a few minutes to complete this New Patient Registration form to the best of your knowledge. Do not hesitate to ask for our assistance. Thank you.

PATIENT INFORMATION

Name____Home Telephone (____)__________________

Date of Birth__________________Age______Social Security #______________Cell # (____)__________________

Address______________________________________City/State/Zip____

Employer____Occupation_________________________________

Address____Telephone__________________

Spouse/Guardian/Other____Occupation______________________

Employer____Telephone__________________

Address____

Work Related Injury? Yes______ No______ **Auto Accident Injury?** Yes______ No______

***If answered yes, is there an existing claim?** Yes______ No______

INSURANCE/BILLING INFORMATION

Primary Insurance Company____

Address____

Name of Insured___________________________________D.O.B.____________Insured SS#______________________

Relationship to_______________ID#_______________________Group#__________________Copay______________

Secondary Insurance Company____

Address____

Name of Insured___________________________________D.O.B.____________Insured SS#______________________

Relationship to_______________ID#_______________________Group#__________________Copay______________

MEDICAL INFORMATION

Referring Physician_____________________________________Referring Dr. Phone Number____________________

Address____

Primary Care Physician (PCP)___________________________________PCP Phone Number____________________

(If different from above)

Address____

Any known allergies?____

Pharmacy____Phone Number______________________

Have you ever seen a Neurologist in the past?________If yes, who/where?_______________________________________

I hereby authorize the release of medical information and/or payment directly to Hartford Neurology, LLC.

Signature____**Today's Date**______________________

HARTFORD NEUROLOGY, LLC
REGISTRATION AND PATIENT QUESTIONNAIRE FORM

Patient:______________________________ **Date:**______________

HISTORY:

Chief Complaint: ______________________________

Present Illness

*Location ______________ *Quality ______________

*Severity ______________ *Duration ______________

*Timing ______________ *Modifying ______________

*Associated Symptoms ______________________________

MEDICAL HISTORY: (check for yes)

____Bleeding Tendency
____Acute Infections
____Venereal Diseases
____Diabetes
____Hypertension
____Cancer
____Stroke
____Heart Trouble
____Arthritis/Gout
____Convulsions/Seizure
____Hereditary Defects

Illnesses, surgeries, and hospitalizations, when? Why?

____
____
____
____
____

Current Medications

____
____
____
____

SOCIAL HISTORY: Check one

Marital status: ___Single ___Married ___Separated ___Divorced ___Widowed

Alcohol use: ___Never ___Rarely ___Moderate ___Daily

Tobacco use: ___Never ___Previously, but quit ___Currently packs/day

Drug use: ___Never ___Rarely ___Moderate ___Daily, type(s):____________

Excessive exposure at work: ___Fumes ___Dust ___Solvents ___Air-borne particles

FAMILY HISTORY:

	Age	Disease	If deceased, cause of death
Father	___	____________	____________
Mother	___	____________	____________
Siblings	___	____________	____________
	___	____________	____________
Spouse	___	____________	____________
Children	___	____________	____________
	___	____________	____________

Have you ever seen a Neurologist before? If so, when and where?
Have you ever had a:

___CAT SCAN or ___MRI SCAN when and where? ______________

___EMG when and where? ______________

___EEG when and where? ______________

___Spinal tap when and where? ______________

Name ___________________________ **Date** ______________

Check for yes

CONSTITUTIONAL SYMPTOMS
___Good general healthy lately
___Fever
___Fatigue
___Headaches

EYES
___Eye disease or injury
___Wear glasses/contact lens
___Blurred or double vision
___Glaucoma

EARS/NOSE/MOUTH/THROAT
___Hearing loss or ringing in the ear
___Earaches or drainage
___Chronic sinus problem or rhinitis
___Nose bleeds
___Mouth sores
___Bleeding gums
___Bad breath or bad taste
___Sore throat or voice change
___Swollen glands in neck

CARDIOVASCULAR
___Heart trouble
___Chest pain or angina
___Palpitations
___Shortness of breath when walking
___Swelling in the feet or ankles

RESPIRATORY
___Chronic or frequent coughs
___Spitting up food
___Shortness of breath
___Asthma or wheezing

GASTROINTESTINAL
___Loss of appetite
___Change in bowel movement
___Nausea or vomiting
___Frequent diarrhea
___Painful bowel movements or constipation
___Rectal bleeding or blood in stool
___Abdominal pain or heartburn
___Peptic ulcer

GENITOURINARY
___Frequent urination
___Burning or painful urination
___Blood in urine
___Incontinence or dribbling
___Change in force of stream when urinating
___Kidney stones
___Sexual difficulty
___Male-testicle pain
___Female: pain with menstruation
___Female: irregular menstruation
___Female: vaginal discharge
___Female: #pregnancies____ #miscarriages____
___Female: last pap smear___________________
___Female: last mammogram________________

MUSCULOSKELETAL
___Joint pain
___Joint stiffness or swelling
___Weakness of muscles or joints
___Muscle pain or cramps
___Back pain
___Cold extremities
___Difficulty walking

INTEGUMENTARY/SKIN and BREAST
___Rash or itching
___Change in nails and hair
___Varicose veins
___Breast pain
___Breast lump
___Breast discharge

NEUROLOGICAL
___Frequent or recurring headaches
___Lightheaded or dizziness
___Convulsions or seizures
___Numbness or tingling sensation
___Tremors
___Paralysis
___Stroke
___Head injury

PSYCHIATRIC
___Memory loss or confusion
___Depression
___Insomnia

ENDOCRINE
___Glandular or hormone problems
___Thyroid disease
___Diabetes
___Excessive thirst or urination
___Heat or cold intolerance
___Skin becoming dry
___Change in hat or glove size

HEMATOLOGICAL/LYMPHATIC
___Slow to heal after cuts
___Bleeding or bruising tendency
___Anemia
___Phlebitis
___Past blood transfusion
___Enlarged glands

ALLERGIC/IMMUNOLOGIC
History of rash or an adverse reaction to:
___Penicillin or other antibiotics
___Morphine, demerol, narcotics
___Novocaine, anesthetics
___Aspirin, pain remedies
___Tetanus or other vaccines
___Iodine or other antiseptics
___Other drugs/medications____________________
___Food allergies______________________________

Physician's Signature___________________________