KCA NEUROLOGY
Get Better...
Better Neurologists. Better Care. Better Results.

Date: _____ How did you hear about KCA? _____

Last Name: _____ First Name: _____ Middle Initial: _____ D.O.B.: _____

What is the main reason you need to see a neurologist? _____

Referring/Primary physician name and phone: _____

How many doctors have you seen for this condition in the past year? Please list names: _____

_____

Please check any medical illnesses for which you have been treated.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Neck Problems
- ☐ Back Problems
- ☐ Heart Disease
- ☐ Seizures/Epilepsy
- ☐ Asthma
- ☐ Fibromyalgia
- ☐ HIV
- ☐ Parkinson's Disease
- ☐ Thyroid Disease
- ☐ Cancer Type: _____
- ☐ Headache
- ☐ Depression/Anxiety
- ☐ Multiple Sclerosis
- ☐ ADHD
- ☐ Dementia
- ☐ High Cholesterol
- ☐ Substance Abuse
- ☐ Automobile Accident w/ injuries
- ☐ Irregular Heartbeat
- ☐ Stroke/TIA
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Neuropathy
- ☐ BiPolar Disorder
- ☐ None

Please check any surgeries you have had, and provide the dates of the procedure.

- ☐ Aneurysm Repair _____ Location of Aneurysm: _____
- ☐ Gallbladder Removal _____
- ☐ Hysterectomy _____
- ☐ Mastectomy _____
- ☐ Pacemaker Placement _____
- ☐ Appendectomy _____
- ☐ Neck Surgery _____
- ☐ Back Surgery _____
- ☐ Tonsillectomy _____
- ☐ Tubal Ligation _____
- ☐ Heart Bypass _____
- ☐ Cataract Surgery _____
- ☐ Carpal Tunnel Release _____
- ☐ Brain Surgery _____
- ☐ Carotid Artery _____
- ☐ Ulcer Surgery _____
- ☐ None _____

Please list any other medical illnesses or surgeries along with the dates:

_____

_____ ☐ None

Please list your medications with strength/dosage (ex: 25 mg tablets; 2 times daily)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ ☐ None

Allergies: _____

Pharmacy: _____ Pharmacy Phone: _____

Do you use tobacco: ○ Yes ○ No Alcohol? ○ Yes ○ No Illegal Drugs? ○ Yes ○ No

Please list any family medical problems currently or in the past for the following family members:

Mother Illness: _____ ○ Deceased ○ Living ○ No Illness

Father Illness: _____ ○ Deceased ○ Living ○ No Illness

Due to the sensitivity of the patients in our office, we kindly ask that you avoid the use of all perfumes and fragrant lotions and sprays when coming to your appointment.

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Please list one main reason for your appointment and up to three related issues.

Main reason for appointment: _____

_____

When did this start? _____

_____

Does anything make the symptom better? _____

_____

Does anything make the symptom worse? _____

_____

How often do you have the symptom? _____

_____

How long does it usually last? _____

Related Issue #1: _____

Does anything make the symptom better? _____

Does anything make the symptom worse? _____

How often do you have the symptom? _____

How long does it usually last? _____

Related Issue #2: _____

Does anything make the symptom better? _____

Does anything make the symptom worse? _____

How often do you have the symptom? _____

How long does it usually last? _____

Related Issue #3: _____

Does anything make the symptom better? _____

Does anything make the symptom worse? _____

How often do you have the symptom? _____

How long does it usually last? _____

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Patient's Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____

D.O.B.: _____ SSN: _____ Sex: ◯M ◯F

Race: _____ Ethnic Group: -- Language: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: ◯Single ◯Married ◯Divorced ◯Widowed Occupation: _____

Living Situation: ◯With Family ◯Alone ◯Assisted Living Facility ◯Nursing Home

Responsible Party Information: If Different From Above

Relationship to Patient: ◯Self ◯Spouse ◯Child ◯Other:

Last Name: _____ First Name: _____ Middle Initial: _____

D.O.B.: _____ SSN: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Insurance Information: Present Insurance Card During Intake

Please bring insurance card to ALL appointments.

Primary Insurance Name: _____ Subscriber ID: _____ Group ID: _____

Name of Policy Holder: _____

D.O.B.: _____ Relationship to Policy Holder: ◯Self ◯Spouse ◯Child ◯Other:

Secondary Insurance Name: _____ Subscriber ID: _____ Group ID: _____

Name of Policy Holder: _____

D.O.B.: _____ Relationship to Policy Holder: ◯Self ◯Spouse ◯Child ◯Other:

Emergency Contact

Name: _____ Relationship: _____ Cell Phone: _____ Home Phone: _____

Name: _____ Relationship: _____ Cell Phone: _____ Home Phone: _____

Patient Medical Information May Be Released To

Name: _____ Relationship: _____ Cell Phone: _____ Home Phone: _____

Name: _____ Relationship: _____ Cell Phone: _____ Home Phone: _____

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YES	NO	
CONSTITUTIONAL		
○	○	Fatigue
○	○	Fever
○	○	Weight Gain (Unintentional)
○	○	Weight Loss (Unintentional)
EYES		
○	○	Blurred Vision
○	○	Sensitivity to Light
○	○	Eye Pain
EARS | NOSE | THROAT		
○	○	Ear Pain
○	○	Hearing Problems
○	○	Ringing in Ears
○	○	Jaw/Facial Pain
CARDIOVASCULAR		
○	○	Skipped Heart Beats
○	○	Swelling in Feet
○	○	Rapid Heart Beat
GASTROINTESTINAL		
○	○	Difficulties Swallowing
○	○	Constipation
○	○	Diarrhea
○	○	Nausea
○	○	Vomiting
GENITOURINARY		
○	○	Genital Lesions
○	○	Frequent Bladder Infections
○	○	Urinating During the Night
○	○	Loss of Bladder Control

YES	NO	
RESPIRATORY		
○	○	Wheezing
○	○	Shortness of Breath
MUSCULOSKELETAL		
○	○	Neck Pain
○	○	Back Pain
○	○	Joint Stiffness/Pain
○	○	Pain in Arms or Legs
NEUROLOGICAL		
○	○	Clumsy Walking
○	○	Confusion
○	○	Dizziness
○	○	Fainting
○	○	Generalized Pain
○	○	Headaches
○	○	Memory Problems
○	○	Nausea/Vomiting
○	○	Numbness/Tingling
○	○	Speech Disorder
○	○	Tremors/Shaking
○	○	Vertigo
○	○	Muscle Weakness
ENDOCRINE		
○	○	Frequent Urination
○	○	Drinking Excessive Water
○	○	Excessive Sweating
PSYCHIATRIC		
○	○	Anxiety
○	○	Depression

Agreement

I hereby give authorization for payment of insurance benefits to be made directly to KCA Neurology, and any assisting physicians for services rendered. I understand that I am responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I further agree that a photocopy of this agreement shall be as valid as the original. I hereby authorize KCA to release all information necessary to secure the payment of benefits. I authorize the use of any messaging person or system, including but not limited to fax, voice-mail, email, or patient portal. I understand that every effort is made to protect my privacy when information is sent to me, or other parties that have the right to receive my information; however, absolute privacy cannot be guaranteed. I have been given the opportunity to read the *Health Insurance Portabilit and Accountability Act* (HIPAA).

I understand that I will be called with urgent test results only. All other results will be provided via patient portal. If I decide to opt out of patient portal, I understand that I will receive my non-urgent results at my next appointment.

I understand that no after hours call service for direct patient telephone consultation/call is provided; however, I do understand that after hours call service company is contracted by KCA at KCA's expense for physicians or their healthcare agents calling on my behalf. In the event of an after hours urgent issue, I understand that I must be evaluated by a health care provider in a walk-in-clinic setting or an emergency room setting.

Patient or Guardian's Signature _____ Date _____