Shore Neurology, P.A.

ADULT NEUROLOGY
ADULT AND PEDIATRIC EPILEPSY
EEG & EMG

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1613 ROUTE 88
BRICK, NJ 08724
732-785-3335 FAX 732-785-2599

Shore Neurology, P.A. Welcomes you as a New Patient!

YOUR APPOINTMENT IS SCHEDULED FOR: _____ AT: _____

WITH DR._____.

PLEASE NOTE:

- MAKE SURE TO **COMPLETE** AND BRING THESE REGISTRATION FORMS TO YOUR APPOINTMENT (DO NOT MAIL OR E-MAIL BACK)
- BRING YOUR INSURANCE CARDS AND REFERRALS (IF NEEDED). YOU WILL **NOT** BE SEEN WITHOUT THESE AND YOUR APPOINTMENT MAY BE RESCHEDULED.
- ALL CO-PAYS AND DEDUCTIBLES ARE TO BE PAID AT THE TIME OF YOUR VISIT
- BRING ALL TESTING INCLUDING CD'S OR FILMS OF CT'S, MRI'S,OR X-RAY'S, BLOODWORK, MEDICATION LIST, AND COPIES OF ALL HEALTH REPORTS WITH YOU; THAT ARE RELATED TOU YOUR VISIT.(DUE TO HIPPA REGULATIONS WE MAY NOT HAVE ACCESS TO THOSE REPORTS)
- *IF YOU NEED TO CANCEL YOUR APPOINTMENT, YOU MUST DO SO WITHIN 24 HOURS. ANY CANCELLATION NOT MADE WITHIN 24 HOURS, OR IF YOU DO NOT SHOW FOR APPOINTMENT, SHORE NEUROLOGY WILL ISSUE A FEE OF $25.00(APPOINTMENTS) OR $50.00(TESTING).*
- THERE ARE TIMES WHEN THE PHYSICIANS ARE CALLED FOR AN EMERGENCY; IF THIS REQUIRES US TO RESCHEDULE YOUR APPOINTMENT WE WILL GIVE YOU ADEQUATE NOTIFICATION IF AT ALL POSSIBLE.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE OFFICE AT (732)240-4787

Shore Neurology, P.A.

Patient Name:_____ Date:_____

Social sec #:_____ DOB:_____ Gender: M___F___ Marital Status: M___S___D___W___

Address:_____ City:_____ State:_____Zip:_____

Phone:_____ Cell:_____ E-mail:_____

Occupation:_____ Work #:_____

Primary Doctor:_____ Primary Dr #:_____

Referring Doctor:_____ Referring Dr #:_____

Emergency Contact

Name:_____ Phone:_____Relationship:_____

Insurance Information

Primary Insurance:_____ Policy#:_____ Group#:_____

Address:_____ City:_____ State:_____Zip:_____

Insurance ph #:_____

Employer:_____ Employer ph #:_____

Is there a referral required? Yes_____ No_____

Secondary Insurance:_____ Policy#:_____ Group#:_____

Important: Is your visit related to any of the following?

Work related injury/worker's compensation case: Yes_____ No_____

Motor Vehicle Accident: Yes_____ No_____

Pending legal action: Yes_____ No_____

I hereby authorize Shore Neurology, P.A. to furnish information to my insurance carriers concerning my diagnosis and treatments. Shore Neurology, P.A. will submit any balances due, to my secondary insurance. Any additional balances that are unpaid will be my responsibility.

Signature:_____ Date:_____

Shore Neurology, P.A.

HIPPA PRIVACY INFORMATION

In order to comply with all Federal and NJ State regulations regarding the privacy of your medical records, please complete the following information:

Do you have an Advanced Directive/Living Will: Yes_____ No _____

Please specify where we may leave messages regarding appointments and medical information (*ie* test results, prescription information, medical recommendations, etc.):

Home Telephone Number: Yes_____ No_____

Cell Phone Number: Yes_____ No_____

Work Number: Yes_____ No_____

With another person: Yes_____ No_____

Through the U.S. Mail: Yes_____ No_____

Via E-mail: Yes_____ No_____ E-mail Address: _____

If you have indicated that we may speak to another person, please list their information below:

NAME	RELATIONSHIP	HOME#	CELL#

1._____

2._____

3._____

4._____

Patient Signature:_____ **Date**:_____

Shore Neurology, P.A.

Patient Medical History

Date:_____

Patient Name:_____ DOB:_____

Left Handed:_____ Right Handed:_____ Both:_____

What is the reason for your visit:_____

_____

_____

Past Medical History :(check all that apply)

High Cholesterol___ High Blood Pressure___ Thyroid___ Heart Problems___ Depression___
Psychiatric___ Kidney___ Diabetes___ Stroke___ Respiratory/Lung___ Fainting___ Cancer___
Epilepsy/seizure___ Sleep disorder___ Other___

Please specify for those you have checked:_____

_____

History of surgeries:_____

_____

Are you: a smoker? No____ Yes____ How many/day____

former smoker? No____ Yes ____ If so, how long ago did you quit?_____

Do you: drink alcohol? No____ Yes____ How many drinks/week ____ Prior alcohol use: No____ Yes____

Use recreational drugs? No____ Yes____ Specify type:_____

Family Medical History:

Mother: Alive_____ Deceased_____ Father: Alive_____ Deceased_____

Do you have any family members with the following: (check all that apply)

High blood pressure___ Headaches___ Aneurysm___ Heart Problems___ Stroke___ Thyroid___

Multiple sclerosis___ Lung disease___ Epilepsy/seizure___ Diabetes___ Kidney Disease___ Cancer___

Psychiatric disease___ Brain Tumor___ Other___ Please specify for those you have checked:_____

_____

Shore Neurology, P.A.

MEDICATION LIST

Patient Name:_____ DOB:_____

Pharmacy: _____ Pharmacy phone#:_____

Drug Allergies: _____

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS, STRENGTH, AND FREQUENCY

Current Medication Name	Strength	Frequency