Palm Beach Neurology
Premiere Research Institute
4631 North Congress Avenue, Suite 200
West Palm Beach, FL 33407
(561) 845-0500

Infectious Disease Screening Tool

Lying on this form could subject you to criminal and civil legal action.

Patient Name:_____ **Date:**_____

Please answer all questions below:

1) Have you had known exposure or tested positive to COVID-19 ? ☐ **Yes** ☐ **No**
   If yes, when _____
   If treated explain:_____

2) Have you had contact with a person with Ebola/Lassa/Marburg, ☐ **Yes** ☐ **No**
   Middle Eastern Respiratory Virus (MERS), Measles, Mumps,
   Chickenpox, or any other known infectious disease?

3) Do you have a fever (Temp more than 100.4°F (38°C)) or feel hot? ☐ **Yes** ☐ **No**

4) Do you have a cough, shortness of breath, or a sore throat ☐ **Yes** ☐ **No**
   If yes, how long have you had these symptoms:_____

5) Are you vomiting or have diarrhea? ☐ **Yes** ☐ **No**

If you answered "yes" to any question, please notify staff IMMEDIATELY for further instructions.

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Tel 561-845-0500
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Last Name:_____ First Name: _____MI_____

DOB:_____ Sex:____ Marital status:_____ SSN:_____

Address:_____

City:_____State:_____Zip:_____

Home:_____ Work:_____

Cellular:_____ Email address:_____

Race: Please select one

- American Indian or Alaska Native
- White
- Asian
- Hispanic
- Black American
- Native Hawaiian
- Other

Ethnicity: Please select one

- Hispanic
- Non-hispanic
- Refuse to report

Medical Information

Referred by:_____ Primary Care Physician_____

Allergies:_____

Pharmacy:_____ Address: _____

Phone:_____Fax:_____

Emergency contact:_____ Phone:_____

Relationship:_____

Who is financially responsible for this bill?_____

Insurance Information

Primary Insurance:_____

Subscriber ID number:_____Group:_____

Insurance address:_____

Primary holder name:_____DOB:_____

Secondary Insurance:_____

Subscriber ID number:_____Group:_____

Authorization

I authorize the release of medical information necessary to process medical benefits and I authorize payment of medical benefits to _____ for services by his/her office.

I understand that **24 hour notice** is needed in the event of cancellation. If less than 24 hour notice is given, there will be a $50.00 cancellation fee for office visit/or $100.00 cancellation for diagnostic testing(EMG/EEG).

If you fail to show up for an appointment, there is a $50.00 no show fee for office visits and $100 no show fee for diagnostic testing (EMG/EEG).

It is the responsibility of the patient to keep an appointment – reminders are a courtesy.

I authorize medical treatment.

Signed_____ Date:_____

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PATIENT MEDICAL HISTORY

Name _____ **Age** _____ **DOB** _____ **Date** _____

Years of Education (H.S. =12) _____ **Handed:** ☐ **Left** ☐ **Right** **Gender:** ☐ **Male** ☐ **Female**

Reason for Visit _____

_____

MEDICATIONS

Medication: Dose

FAMILY HISTORY
(Relatives, Excluding Self)

Disease	No	Yes
Alzheimer's	☐	
Headache	☐	
Cancer	☐	
Epilepsy	☐	
Heart Disease	☐	
High Blood Pressure	☐	
Diabetes	☐	
Stroke	☐	
Anxiety, Depression, Panic Attacks or OCD	☐	
Problems with Attention or Learning (i.e. AHDH)	☐	
Obesity	☐	
Other	☐	

Drug / Allergies

1. _____
2. _____
3. _____
4. _____

Do you smoke? ☐ Yes ☐ No

How much? _____

Do you drink Alcohol? ☐ Yes ☐ No

How much? _____

For Women Only

Menstrual Periods
☐ Regular ☐ irregular ☐ none

Last Menses _____

Are you taking birth control pills?
☐ Yes ☐ No

Is there a possibility you might be pregnant?
☐ Yes ☐ No

Are you trying to get pregnant?
☐ Yes ☐ No

Please Fill Out Page 2 ➤➤

Please circle below if you have had any of these symptoms/problems

Constitutional: fever / chills / significant weight loss or weight gain

Eyes: visual difficulties / double vision

Ears, Nose, Mouth, Throat: difficulty hearing / swallowing issues / sore throat / dizziness

Cardiovascular: chest pain / shortness of breath / high blood pressure / heart attack

Respiratory: any pulmonary issues / wheezing

Gastrointestinal: nausea / vomiting / diarrhea / blood in stool

Genitourinary: urinary difficulties / blood in urine

Musculoskeletal: recent injury / significant joint pain

Skin: rash / bruising

Neurologic: history of stroke / seizure / numbness / weakness / headache / neck pain / back pain

Psychiatric: sadness / depression / significant anxiety / suicidal

Endocrine: diabetes / thyroid problems

Hematologic / Lymphatic: low blood count / blood disorders

History of Cancer: yes / no type: _____

Surgeries or Hospitalizations	Date	Surgeries or Hospitalizations	Date
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Palm Beach Neurology

PATIENT CONTACT CONSENT FORM

All calls from Palm Beach Neurology regarding your care, test results and appointments will be made to your home telephone number unless an alternate number is requested below. If you would like us to contact an alternate telephone number, other then number on file, please indicate below.

( ) _____

_____ I hereby authorize the above-mentioned medical practice to contact me by telephone and if I am not present, they may leave a message on my answering machine.

_____ **DO NOT** leave a message on answering machine other than name of caller and telephone number.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By Signing this form, you are giving person(s) mentioned below to have access to your medical condition, billing information, medical records, and speak with health care professional on your behalf.

_____	_____	_____
Name	Relationship	Telephone Number
_____	_____	_____
Name	Relationship	Telephone Number

I authorize name(s) mentioned above to have access to my medical condition, billing information and medical records on my behalf. I give them consent to speak with healthcare professional regarding my medical condition and/any billing information and access to my medical records.

Print Name:_____ Patient Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement but, in refusing we *will not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for _____. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR MEDICAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY MEDICAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY MEDICAL HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Text Message
- ☐ Email Message
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW MEDICAL INFO** via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____

Signature of Privacy Officer

PALM BEACH NEUROLOGY

4631 N. CONGRESS AVE. STE 200
WEST PALM BEACH, FL 33407
(561) 845-0500 FAX (561)845-0587 OR (561)845-1794

AUTHORIZATION TO USE AND OR DISCLOSE HEALTH INFORMATION

I, _____, DOB_____, SSN_____
Authorize (provider name) _____
To use and or disclose my health information as identified below:

_____
Telephone and fax numbers of provider you are requesting this information from:

Phone number _____ Fax _____
Phone number _____ Fax _____

Forward medical records to _____

By initialing spaces below, I specifically authorize the use or disclosure of the following health information and/or records if such information and or records exist.

____ Lab reports
____ Billing Statements
____ Emergency and urgent care records
____ Diagnostic imaging reports
____ Clinician notes
____ Other

The following items must be initialed to be included in the use of disclosure of health information:

____ HIV/AIDS related health information/or records
____ Mental health information or records
____ Drug/Alcohol diagnosis, treatment and or referral information

Federal Regulation requires a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.

I understand that I may revoke the authorization at anytime by giving written notice to PALM BEACH NEUROLOGY. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert applicable date of event of expiration)._____

_____ _____
Signature of individual's legal representative Date

_____ _____
Print the name of legal representative Relationship of legal representative

A copy of this signed form will be provided to the individual and or the individual's legal representative.