

PATIENT REGISTRATION SHEET

Account# _____
JWM MD _____

IN ORDER TO PROCESS YOUR CLAIM PROPERLY & ADHERE TO THE HIPAA REQUIREMENTS, ALL APPLICABLE INFORMATION MUST BE COMPLETED IN FULL

Date HIPAA Form Signed: _____ (Office Use Only)

PATIENT INFORMATION

Patient's Name: _____ Male Female Birthdate: _____
Last First Middle Initial Please Circle

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell Phone: _____

Patient's Social Security #: _____ E-mail: _____

Referring Physician: _____ Referring Physician Phone #: _____

Primary Care Physician: _____ Primary Care Physician Phone #: _____

Spouse's Name: _____ Spouse's Daytime Phone #: _____

Emergency Contact: _____ Phone#: _____ Relationship: _____

RESPONSIBLE PARTY-Guarantor of the Account-statements will be mailed to this address
 If guarantor is same as patient, acceptable to indicate "same".

Name: _____ Male Female
Last First Middle Initial Please Circle

Date of Birth: _____ Patient's relationship to the responsible party: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone _____

PRIMARY INSURANCE INFORMATION-if applicable
Copy of Insurance Card is Required

Name of Primary Insurance: _____ Insurance Phone #: _____

Claims mailing address:
 Street: _____ City: _____ State: _____ Zip: _____

Policyholder Information:
 Name: _____ Male Female
Last First Middle Initial Please Circle

Date of Birth: _____ Patient's relationship to the Policyholder: _____

Policyholder Social Security #: _____ Policyholder's Employer: _____

Insurance Policy #: _____ Insurance Group #: _____

Type of Policy: Group Plan • Individual Plan • HMO • PPO • Auto

SECONDARY INSURANCE INFORMATION-if applicable
Copy of Insurance Card is Required

Name of Secondary Insurance: _____ Insurance Phone #: _____

Claims mailing address:

Street: _____ City: _____ State: _____ Zip: _____

Policyholder Information:

Name: _____ **Male Female**
Last First Middle Initial Please Circle

Date of Birth: _____ Patient's relationship to the Policyholder: _____

Social Security #: _____ Policy Holder's Employer: _____

Insurance Policy #: _____ Insurance Group #: _____

Type of Policy: Group Plan • Individual Plan • HMO • PPO • Auto • Supplemental

WORKER'S COMPENSATION AND/OR ACCIDENT INFORMATION-if applicable

Date of Injury: _____ Job related: **Y/N** Auto related: **Y/N**

Claims mailing address: _____ City: _____ State: _____ Zip: _____

WORKER'S COMPENSATION INFORMATION: Case #: _____

Employer Name: _____ Contact Person: _____ Phone #: _____

AUTO ACCIDENT INFORMATION:

Name of Insurance: _____ Insurance Phone #: _____

Policyholder Information:

Name: _____ **Male Female**
Last First Middle Initial Please Circle

Date of Birth: _____ Social Security #: _____

Claim/Policy #: _____

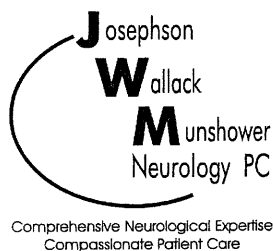
Assignment of benefits: I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other plans to Josephson, Wallack & Munshower Neurology PC. This assignment will remain in effect until revoked by me in writing. I hereby agree to pay Josephson, Wallack & Munshower Neurology PC, the charges for all medical services rendered. I shall also be responsible for any attorney fees required to collect for these services, court costs, and collection agency fees, to which may be added pre-judgement and /or post-judgement interest at the current legal rate.

Signature: _____ Date: _____

Authorizaton for Release of Information: I hereby authorize Josephson, Wallack & Munshower Neurology PC to furnish such professional information as may be necessary to complete my insurance claim from the medical records compiled during my treatment and are hereby released from all legal liability that may arise from the release of the information requested.

Signature: _____ Date: _____

Witness: _____



HEALTH HISTORY DATA SHEET

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: _____

Check (X) below any illness the patient has had:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Asthma
<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Behavioral Problems
<input type="checkbox"/> Bleeding Tendencies
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Cancer-Tumors
<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Eczema
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Eye Disease
<input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hernia
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Measles
<input type="checkbox"/> Meningitis
<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Mumps
<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Otitis Media
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Seizures
<input type="checkbox"/> Skin Diseases
<input type="checkbox"/> Stomach Trouble
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Urinary Tract/
Bladder Infection
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Gynecologic Problems | <input type="checkbox"/> Allergies(Food/Drug)
Please List:

_____ |
|---|--|--|---|

LIST OTHER ILLNESSES:

OPERATIONS: (TYPE)

DATE

HOSPITAL

PREGNANCIES:

--	--	--

FRACTURES:

--	--	--

LIST MEDICATIONS NOW TAKING, INCLUDING VITAMINS, OVER-THE-COUNTER MEDICATIONS, AND BIRTH CONTROL PILLS.

IMMUNIZATION

YEAR

- | | |
|-------------------------------------|-------|
| <input type="checkbox"/> Diphtheria | _____ |
| <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Tetanus | _____ |
| <input type="checkbox"/> Measles | _____ |
| <input type="checkbox"/> Mumps | _____ |
| <input type="checkbox"/> Rubella | _____ |

IMMUNIZATION

YEAR

- | | |
|--------------------------------------|-------|
| <input type="checkbox"/> Smallpox | _____ |
| <input type="checkbox"/> Pertussis | _____ |
| <input type="checkbox"/> Hepatitis | _____ |
| <input type="checkbox"/> Hem. Influ. | _____ |
| <input type="checkbox"/> Pneumonia | _____ |

HABITS

(Please indicate past and current usage and frequency per day.)

- AMOUNT
- Cigarettes _____
- Beer _____
- Wine _____
- Whiskey _____
- Other _____

EDUCATION

- YEARS COMPLETED
- Grade School _____
- High School _____
- College (no. of years) _____
- Graduate _____
- Other _____

TYPE OF WORK

NUMBER OF CHILDREN

MARITAL STATUS:

- Married Single Divorced Other

FAMILY HISTORY:

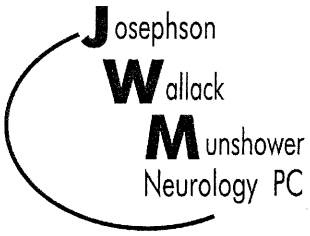
(Check below if any of the conditions have occurred on either side of patient's family.)

- Allergies Epilepsy
- Bone Disease Gastrointestinal Disease
- Blood Disease Mental Disease
- Cancer or Tumors Migraine
- Cardiovascular Disease (Heart) Pulmonary Disease (Lung)
- Congenital Deformities Kidney Disease
- Deafness Thyroid Disease

- Tuberculosis

LIST OTHER ILLNESSES:

	IF LIVING Health Status				Known Illnesses	AGE AT DEATH	IF DECEASED Cause of Death
	A G E	G O O D	F A I R	P O O R			
Father							
Mother							
Brothers							
Sisters							



Comprehensive Neurological Expertise
Compassionate Patient Care

REVIEW OF SYSTEMS

Name: _____

Date: _____

Do you have now or have you had within the past year?

Weight loss/ Appetite Change _____	YES _____	NO _____
Thyroid problems _____	YES _____	NO _____
Fevers/Chills _____	YES _____	NO _____
Sinus problems _____	YES _____	NO _____
Vision problems _____	YES _____	NO _____
Hearing problems _____	YES _____	NO _____
Seasonal or environmental allergies _____	YES _____	NO _____
Neck Pain _____	YES _____	NO _____
Back Pain _____	YES _____	NO _____
Joint Pain _____	YES _____	NO _____
Chest Pain _____	YES _____	NO _____
Rashes _____	YES _____	NO _____
Diabetes _____	YES _____	NO _____
Breathing problems _____	YES _____	NO _____
Heart disease _____	YES _____	NO _____
High blood pressure _____	YES _____	NO _____
Kidney problems _____	YES _____	NO _____
Stomach problems _____	YES _____	NO _____
Bowel Problems _____	YES _____	NO _____
Nausea/Vomiting _____	YES _____	NO _____
Anemia _____	YES _____	NO _____
Depression _____	YES _____	NO _____
Psychiatric problems _____	YES _____	NO _____
Cancer _____	YES _____	NO _____
Stroke _____	YES _____	NO _____
Seizures _____	YES _____	NO _____
Headaches _____	YES _____	NO _____
Gynecologic Problems _____	YES _____	NO _____