Welcome To Neurology Associates

Neurology Associates is excited to announce a recent upgrade from paper charts to a complete electronic healthcare environment. This allows us to serve our patients with significant improvements in efficiency, patient safety and HIPPA protections. In order to streamline your visit, we now require all patients to go online to fill out our Registration Forms. To begin this process, go online to: www.neurologyassociates.org in the left hand corner of the homepage, click on My patient Page. You will then see a page that outlines the different options that are available through our website. Once you have read through the many options, please click on New User and Create an Account, then click Join. Now you are able to complete your registration forms by clicking on the tab at the top of the page. There are 3 forms that need to be completed prior to your appointment.

1) HIPPA Restrictions Questionnaire

2) Neurology Facesheet

3) PT information Sheet

These forms need to be completed prior to your appointment with us. If you do not have access to the internet, please fill out the enclosed forms. Patients who come in without completed forms may have a delay in being seen.

Please use our website for the following communications:

Prescription Renewal:

Please get all medications needed until next follow up. If for some reason you run low on medication, please contact us through this site.

Ask A Doctor:

Through this feature you are able to request test results, or ask your health care provider a question. Please remember to try to keep this as simple and to the point in order for a prompt response. Any matter that your health care provider feels is more than we are able to efficiently handle over the site will require a follow up appointment.

Appointment Scheduling:

Appointments can be requested through this site by selecting at least 3 options that work with your schedule. If you feel that you need to be seen in a faster manner, please use the Ask A Doctor section to update us on your condition.

We will attempt to respond in a timely fashion, and as with phone calls, all e-mail correspondence is triaged according to medical necessity. Please contact us if any assistance is needed.
DATE: ___________________  PATIENT NAME: ___________________  PREFERRED NAME: ___________________

DATE OF BIRTH: ________________  SEX: __________  SS#: ________________  RACE: ________________  CREDENTIALS: ________________

MARITAL STATUS: ________________  PRIMARY LANGUAGE: ________________  RELIGION: ________________

ADDRESS:

Street

Apt. #

City

St.

Zip

PHONE: HOME: ________________  WORK: ________________  CELL: ________________  PRIMARY #: ________________

PHARMACY NAME: ________________

TOWN: ________________

PRIMARY CARE PHYSICIAN:

First: ________________

Last: ________________

PHONE NUMBER: ________________

PRIMARY GROUP NAME: ________________

REFERRING PHYSICIAN:

First: ________________

Last: ________________

PHONE NUMBER: ________________

REFERRING GROUP NAME: ________________

EMPLOYER: ________________

WORK PHONE/EXT: ________________

EMPLOYER ADDRESS: ________________

OCCUPATION: ________________

IS THIS A WORKMEN'S COMPENSATION INJURY? YES ___ NO ___

IS THIS A RESULT OF AN AUTO ACCIDENT? YES ___ NO ___

IS THIS A RESULT OF ANY OTHER TYPE OF ACCIDENT? YES ___ NO ___

PLEASE PROVIDE YOUR EMAIL ADDRESS IF YOU ARE INTERESTED IN CORRESPONDING WITH YOUR DOCTOR

MAY WE CONTACT YOU AT HOME OR LEAVE A MESSAGE ON YOUR MACHINE TO CONFIRM YOUR UPCOMING APPOINTMENTS? YES ___ NO ___

PERSON TO CONTACT IN EMERGENCY: ________________

PHONE: ________________

( ) PRIMARY INS

GUARANTOR'S NAME: ________________

ID#: ________________

GROUP#: ________________

DOB: ________________

GUARANTOR'S EMPLOYER NAME: ________________

( ) SECONDARY INS

GUARANTOR'S NAME: ________________

ID#: ________________

GROUP#: ________________

DOB: ________________

GUARANTOR'S EMPLOYER NAME: ________________

AGREEMENT TO PAY AND MEDICAL RECORDS RELEASE

I agree that in the event my account should become delinquent, I will pay all reasonable attorney fees, collection fees, court costs, or any other expenses pertaining to the collection of such account, whether or not a lawsuit is commenced.

I authorize the release of any medical information to consulting health professionals and that which is necessary for the processing of insurance. I assign all medical and/or surgical benefits to NEUROLOGY ASSOCIATES. A copy of this assignment is to be considered as valid as an original.

I consent to evaluation and treatment as directed by a licensed physician.

Patient's Signature (or Legal Guardian if patient is a minor)

Date

SERVER\DOCUMENTFORMS\NEW PATIENT FORMSFRT INFO SHEET MATCH GREENWAY 11-13-2007  LAST UPDATED 9/11/2011
Neurology Associates

Name ___________________________ DATE _______________ Reason for visit: ___________________________

Height: __________ Weight: __________ Please circle one: RIGHT HANDED LEFT HANDED

Please fill out both pages of this form completely. This information is a confidential record.

Have you ever had any of the following (circle all that apply)

<table>
<thead>
<tr>
<th>Anemia</th>
<th>COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aneurysm</td>
<td>Depression</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Diabetes Type I</td>
</tr>
<tr>
<td>Asthma</td>
<td>Diabetes Type II</td>
</tr>
<tr>
<td>Blood Clots</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>Cancer—what kind?</td>
<td>Glaucoma</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Hepatitis—what kind?</td>
</tr>
<tr>
<td>Lyme disease</td>
<td>Migraine headaches</td>
</tr>
<tr>
<td>PACEMAKER</td>
<td>DEFIBRILLATOR</td>
</tr>
<tr>
<td>Lyme disease</td>
<td>Migraine headaches</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>Heart Attack</td>
</tr>
<tr>
<td>Sexual Dysfunction</td>
<td>Thyroid Disorder</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>NONE</td>
</tr>
</tbody>
</table>

List all Surgeries and Procedures  NONE

<table>
<thead>
<tr>
<th>Surgery/Procedure</th>
<th>Year Performed</th>
<th>Surgery/Procedure</th>
<th>Year Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List all medications and supplements you take regularly  NONE

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency (how often)</th>
<th>Prescribing Physician (or state if over the counter)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list all medication allergies and the reaction you have if you take them  NONE

<table>
<thead>
<tr>
<th>Allergic To:</th>
<th>Reaction</th>
<th>Allergic To:</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Family History  Are You Adopted?  Yes  No

Has any blood relative had any of the following? Circle the problem and indicate which relative: for example, "maternal grandmother"

<table>
<thead>
<tr>
<th>Problem</th>
<th>Family Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aneurysm</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Blood Disorder</td>
<td>Migraines</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Stroke</td>
</tr>
<tr>
<td>Cancer—what kind?</td>
<td>Other Pertinent neurological diseases/symptoms</td>
</tr>
<tr>
<td>Alzheimer's (Dementia)</td>
<td></td>
</tr>
</tbody>
</table>

Social History

Highest level in school: Some high school  GED  High school Attendee  College  A.D.  B.A.  B.S.  M.A.  P.h.D

Marital status  Single  Engaged  Married  Divorced  Widowed

What is your current occupation? ___________________________

Do you smoke?  Never  Quit—when?  Yes—how much per day?

Do you drink alcohol?  Never  Former  Yes—how much and how often?

Do you use illegal drugs?  Never  Former  Yes—what kind, how much and how often?
### REVIEW OF SYSTEMS

Do You Have Now or Have You Had Recently (circle all that apply)

<table>
<thead>
<tr>
<th>Weight Loss</th>
<th>Vertigo</th>
<th>Difficulty urinating</th>
<th>Incoordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Gain</td>
<td>Blackouts</td>
<td>Urinary incontinence</td>
<td>Sensory loss</td>
</tr>
<tr>
<td>Chronic fatigue</td>
<td>Breast lumps</td>
<td>Painful sex</td>
<td>Tingling or numbness</td>
</tr>
<tr>
<td>Persistent Fever</td>
<td>Nipple discharge</td>
<td>Impotence</td>
<td>Pain in extremities</td>
</tr>
<tr>
<td>Night sweats</td>
<td>Chest pain</td>
<td>Genital sores</td>
<td>Difficulty walking</td>
</tr>
<tr>
<td>Unusual diet</td>
<td>Shortness of breath</td>
<td>Rash</td>
<td>Generalized weakness</td>
</tr>
<tr>
<td>Visual loss</td>
<td>Wheezing</td>
<td>Difficulty concentrating</td>
<td>Tremors</td>
</tr>
<tr>
<td>Change in vision</td>
<td>Difficulty swallowing</td>
<td>Memory difficulties</td>
<td>Uncontrolled movements</td>
</tr>
<tr>
<td>Double vision</td>
<td>Abdominal pain</td>
<td>Difficulty speaking</td>
<td>Daytime sleepiness</td>
</tr>
<tr>
<td>Visual floaters</td>
<td>Diarrhea</td>
<td>Slurred speech</td>
<td>Joint pain</td>
</tr>
<tr>
<td>Headaches</td>
<td>Constipation</td>
<td>Difficulty with language</td>
<td>Leg pain</td>
</tr>
<tr>
<td>Hearing loss</td>
<td>Fecal incontinence</td>
<td>Seizures</td>
<td>Back pain</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Tinnitus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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I authorize the release of any medical information to consulting health professionals and that which is necessary for the processing of insurance. I assign all medical and/or surgical benefits to include major medical benefits to NEUROLOGY ASSOCIATES. A copy of this assignment is to be considered as valid as an original.

I consent to evaluation and treatment as directed by a licensed physician.

Patient's Signature (or Legal Guardian if patient is a minor)  

Date
PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

PATIENT NAME: ___________________________ D.O.B. __________________

It is the policy of Neurology Associates, LLC to closely work with those involved in providing medical care to the patient. Unless otherwise indicated, the sharing of medical information will be restricted to the immediate family.

The patient may request that the list of people involved with their care be expanded or restricted. In these instances the patient will complete this form. The patient has the right to amend this information at anytime.

Please check all boxes where sharing of medical information is appropriate. Add any qualifiers or restrictions as required.

☐ Spouse Name: ___________________________

☐ Children Name: _________________________

☐ Parent Name: ___________________________

☐ Other Family Member: Name: _____________

☐ Other—Please Specify: Name: __________________

Signed: ___________________________ Date: ____________

Signature of Patient or Legal Representative

I give permission for information to be left on my answering machine. Please check all that apply. Home Phone #: ___________________________ Cell #: ___________________________

Additional phone #: ___________________________

☐ Test Results

☐ Appointments for tests and doctor visits

☐ Information regarding prescriptions I am taking or any changes in prescriptions

Signed: ___________________________ Date: ____________
Neurology Associates  
One Towne Park Plaza  
Norwich, CT 06360  
860-886-1433

Please note: Strong fragrances can trigger migraine headaches or breathing difficulties in some individuals. For the comfort of our patients, please refrain from wearing perfume or cologne in our office. Thank you

Directions

• From the South – using Interstate 395 North:  
  Take exit 82; turn right at the end of the ramp. Proceed to the Norwichtown Friendly’s Restaurant (on your left). Turn into Friendly’s parking lot. We are in the brick building behind them.

• From the North – using Interstate 395 South:  
  Take exit 82; turn left at the end of the ramp. Proceed to the Norwichtown Friendly’s Restaurant (on your left). Turn into Friendly’s parking lot. We are in the brick building behind them.

• From Hartford:  
  Take Route 2 east to exit 27. Turn left onto West Town Street. Proceed through the over-pass and the next 5 traffic lights to the Norwichtown Friendly’s Restaurant. Turn into Friendly’s parking lot. We are in the brick building behind them.

• From Willimantic:  
  Take Route 32 South. After crossing the Norwichtown line, stay in the left lane for West Town Street. Proceed through the over-pass and the next 5 traffic lights to the Norwichtown Friendly’s Restaurant. Turn into Friendly’s parking lot. We are in the brick building behind them.

• From Groton using Route 12:  
  Take Route 12 to the Mohegan Bridge. Cross the bridge and bear right onto 395 North. Take exit 82; turn right at the end of the ramp. Proceed to the Norwichtown Friendly’s Restaurant (on your left). Turn into Friendly’s parking lot. We are in the brick building behind them.

• If using Mapquest or GPS:  
  Use the address 105 West Town Street, Norwich CT 06360. Turn into Friendly’s parking lot. We are in the brick building behind them.