



Carolina Neurology & Electromyography

American Board of Psychiatry & Neurology
American Board of Electrodiagnostic Medicine
Certified by American Society of Neuroimaging
Botox Therapy Specialist Since 1990

707 W.H. Smith Blvd. Greenville, NC 27834
Office: (252) 758-0806 Fax: (252) 551-5721
Website: www.carolinaneurology.com

Please complete the enclosed form(s) prior to your appointment at Carolina Neurology and Electromyography. This information is an important part of your Carolina Neurology medical record and is required for proper handling of insurance and financial arrangements.

Please complete the following steps:

1. Complete the information on every form prior to your appointment.
2. Sign the form(s) with a black or blue ink pen.

So that your appointment is as safe and efficient as possible, we ask that you make sure that you complete the following tasks prior to your visit to Carolina Neurology and Electromyography. It is up to you to bring these materials to your appointment so that we can provide safe and efficient care for you. If you do not complete these tasks in advance, delays may result during your evaluation.

*A current list of medications (prescription and non-prescription like over-the-counter medications, herbal products and vitamins). Be sure to fill out the medication list on the History and Physical form. Bring all of your medications to this appointment as well.

*Medical records pertaining to your current neurological problem and related past problems.

*Radiology studies (MRI, MRA, CT, SPECT, PET, and Angiogram). It is critical that you bring the actual images: radiology reports alone are not adequate. We prefer these be on CDROM. If that is not possible, the actual films are acceptable. Contact the clinic or hospital where these were performed to get these prior to coming to Carolina Neurology. We do not have a system in place to do this for you. Bring these yourself; do not have them mailed.

This appointment will consist of a thorough history of your problem, a neurologic examination, and consultations. Some patients find it helpful to write a narrative description of their situation, which may be of assistance to your physician in obtaining a detailed history.

Carolina Neurology and Electromyography serves patients and their families with respect, courtesy and responsiveness. We are committed to maintaining patient confidentiality and respect each patient's cultural, psychosocial, spiritual and personal values, beliefs and preferences.

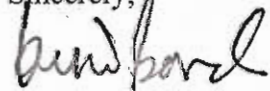
To provide the best possible care, we ask that our patients accept their responsibility to share accurate information about themselves and their health, ask questions if they are unclear about their diagnosis and/or treatment, and respect the rights of others by following Carolina Neurology's rules and regulations.

We also ask that our patients meet their financial obligations. Patient account representatives are available to assist you with the financial aspects of your care by calling (252) 758-0806.

If you are unable to keep your appointment, please notify us as soon as possible so we can make this time available to another patient. Our policy is to charge \$50.00 if no notice is given within 24 hours of your appointment time that must be paid prior to rescheduling your appointment.

If you have additional questions concerning your appointment, please contact us at (252) 758-0806.

Sincerely,



Kevin Good, M.D.
Carolina Neurology and Electromyography



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OFFICE POLICIES

Our commitment is to provide you with the best possible patient care. We are anxious to help you receive that care by your understanding the following office policies.

Payment for services are due at the time services is rendered. We accept cash, checks, MasterCard or Visa. The assessed return check fee is \$30.00. Failure to make restitution within 10 days may result in legal action. This could also prevent the acceptance of your check in the future.

We must emphasize that as a health care provider, our relationship is with you, not your insurance company. It is your responsibility to understand your insurance policy for your specialist benefits. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. You are required to notify us of any insurance change within 60 days.

Your next appointment time will be made at the checkout window. If you are unable to keep an appointment, please notify the office 24 hours in advance during business hours. Failure to do so will result in a \$50.00 charge for the missed appointment.

There is a \$25.00 charge for completion of all disability/insurance forms (8 1/2 x 11). There is a \$25.00 charge for copies of patients' medical records if used for personal records.

Patients Signature

Date



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PATIENT INFORMATION FORM

Name _____ Home Phone _____ Work Phone _____
Home Address _____ City _____ Zip _____
Social Security # _____ Date of Birth _____
Spouse's Name _____ Work Phone _____
Family Physician _____ Phone _____
Referring Physician _____ Phone _____
Whom may we contact in case of emergency? _____ Phone _____
Insurance Company _____ Policy # _____
Policy Holder's Name _____ Relationship _____
Social Security # _____ Date of Birth _____
Employer _____

I authorize Carolina Neurology and Electromyography to provide medical treatment to me and to release any information acquired in the course of my treatment to my insurance company. Carolina Neurology and Electromyography is not responsible for the confidentiality of information given to your insurance company.

Signature _____ Date _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. Should my account become delinquent and require collection service, I agree to pay all reasonable collection and handling charges on the outstanding balance.

Signature _____ Date _____

HISTORY & PHYSICAL

NAME _____ SS# _____ Date _____
Phone (Home) _____ (Work) _____ Date of Birth ____ / ____ / ____ Age _____
REFERRING PHYSICIAN _____ FAMILY DOCTOR _____

REASON YOU ARE HERE

CURRENT MEDICATIONS

	Changes	Date
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____

ALLERGIES TO MEDICATIONS OR DYE

SOCIAL HISTORY

Do you smoke cigarettes? Yes No Have you smoked regularly? Yes No When? _____ How Often? _____
Alcohol use? Yes No How often? _____ Married Single Divorced Widowed

MEDICAL HISTORY

List illnesses for which doctors have treated you previously

- | | | |
|---|--|--|
| <input type="checkbox"/> HEADACHE / MIGRAINE _____ | <input type="checkbox"/> MURMUR _____ | <input type="checkbox"/> GENITOURINARY DISEASE _____ |
| <input type="checkbox"/> HEADACHE / TENSION _____ | <input type="checkbox"/> HYPERTENSION _____ | <input type="checkbox"/> VENEREAL DISEASE _____ |
| <input type="checkbox"/> EPILEPSY / SEIZURES _____ | <input type="checkbox"/> CHRONIC OBSTRUCTIVE PULMONARY DISEASE _____ | <input type="checkbox"/> ARTHRITIS _____ |
| <input type="checkbox"/> CEREBROVASCULAR _____ | <input type="checkbox"/> PNEUMONIA _____ | <input type="checkbox"/> CANCER _____ |
| <input type="checkbox"/> OTHER NEUROMUSCULAR _____ | <input type="checkbox"/> ASTHMA _____ | <input type="checkbox"/> TUBERCULOSIS _____ |
| <input type="checkbox"/> HEAD INJURY _____ | <input type="checkbox"/> PEPTIC ULCER DISEASE _____ | <input type="checkbox"/> HIV _____ |
| <input type="checkbox"/> SPINAL CORD INJURY _____ | <input type="checkbox"/> COLONIC POLYPS _____ | <input type="checkbox"/> ALCOHOL _____ |
| <input type="checkbox"/> CERVICAL SPINE DISEASE _____ | <input type="checkbox"/> BLEEDING DISORDER _____ | <input type="checkbox"/> SMOKING _____ |
| <input type="checkbox"/> LUMBAR SPINE DISEASE _____ | <input type="checkbox"/> ANEMIA _____ | <input type="checkbox"/> DRUG USE _____ |
| <input type="checkbox"/> PERIPHERAL NERVE _____ | <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> EXPOSURES _____ |
| <input type="checkbox"/> CNS MALIGNANCY _____ | <input type="checkbox"/> PERIPHERAL VASCULAR DISEASE _____ | <input type="checkbox"/> MUMPS _____ |
| <input type="checkbox"/> DEPRESSION _____ | <input type="checkbox"/> THYROID DISEASE _____ | <input type="checkbox"/> MEASLES _____ |
| <input type="checkbox"/> CORONARY ARTERY DISEASE _____ | <input type="checkbox"/> MENSTRUAL / SEXUAL DYSFUNCTION _____ | <input type="checkbox"/> POLIO _____ |
| <input type="checkbox"/> MYOCARDIAL INFARCTION _____ | <input type="checkbox"/> OTHER ENDOCRINE _____ | <input type="checkbox"/> RHEUMATIC FEVER _____ |
| <input type="checkbox"/> ARRHYTHMIAS _____ | <input type="checkbox"/> LIVER DISEASE / HEPATITIS _____ | <input type="checkbox"/> ALLERGY / HAY FEVER _____ |
| <input type="checkbox"/> CONGESTIVE HEART FAILURE _____ | <input type="checkbox"/> RENAL DISEASE _____ | <input type="checkbox"/> OTHER _____ |

PRIOR SURGERIES / HOSPITALIZATIONS

Reason / Date _____

Pregnant Now? Yes No

Do you use birth control pills? Yes No

REVIEW OF SYSTEMS - General

<input type="checkbox"/> Fever _____ <input type="checkbox"/> Chills _____ <input type="checkbox"/> Night sweats _____ <input type="checkbox"/> Weight loss _____ <input type="checkbox"/> Weight gain _____ <input type="checkbox"/> Fatigue _____ <input type="checkbox"/> Tires easily _____ <input type="checkbox"/> Sinus _____ <input type="checkbox"/> Ear _____ <input type="checkbox"/> Throat _____ <input type="checkbox"/> Eyes _____ <input type="checkbox"/> Conjunctival effusions _____ <input type="checkbox"/> Shortness-of-breath _____ <input type="checkbox"/> Wheezing _____ <input type="checkbox"/> Coughing _____ <input type="checkbox"/> Chest discomfort _____ <input type="checkbox"/> Chest pain _____ <input type="checkbox"/> Dyspnea (shortness of breath) on exertion _____ <input type="checkbox"/> Nocturnal dyspnea _____ <input type="checkbox"/> Diaphoresis (sweating) _____ <input type="checkbox"/> Numbness, pain, weakness of legs with exercise (walking) _____ <input type="checkbox"/> Nausea _____ <input type="checkbox"/> Vomiting _____ <input type="checkbox"/> Dysphagia _____	<input type="checkbox"/> Cramping _____ <input type="checkbox"/> Diarrhea _____ <input type="checkbox"/> Constipation _____ <input type="checkbox"/> UTI's _____ <input type="checkbox"/> Urinary incontinence _____ <input type="checkbox"/> Difficulties with emptying the bladder-increased frequency/urgency _____ <input type="checkbox"/> Difficulties with initiating urination _____ <input type="checkbox"/> Pain with urination _____ <input type="checkbox"/> Blood in urine _____ <input type="checkbox"/> Abnormal bleeding _____ <input type="checkbox"/> Pelvic pain _____ <input type="checkbox"/> Uterine discharges _____ <input type="checkbox"/> Breast masses _____ <input type="checkbox"/> Breast discharges _____ <input type="checkbox"/> Hot flashes _____ <input type="checkbox"/> Rashes _____ <input type="checkbox"/> Jaundice (yellow skin) _____ <input type="checkbox"/> Cyanosis (blue skin) _____ <input type="checkbox"/> Skin changes _____ <input type="checkbox"/> Joint pain _____ <input type="checkbox"/> Joint swelling _____ <input type="checkbox"/> Muscle pain _____ <input type="checkbox"/> Cramping _____ <input type="checkbox"/> Anemia _____	<input type="checkbox"/> Abnormal bleeding _____ <input type="checkbox"/> Lymph node swelling _____ <input type="checkbox"/> Excessive bruising _____ <input type="checkbox"/> Depression _____ <input type="checkbox"/> Psychosis _____ <input type="checkbox"/> Post traumatic stress _____ <input type="checkbox"/> Anxious _____ <input type="checkbox"/> Personality changes _____ <input type="checkbox"/> Polydipsia (increased thirst) _____ <input type="checkbox"/> Polyuria (frequent urination) _____ <input type="checkbox"/> Polyphagia (excessive eating) _____ <input type="checkbox"/> Feeling cold _____ <input type="checkbox"/> Feeling warm _____ <input type="checkbox"/> Food allergies _____ <input type="checkbox"/> Environmental allergies _____ <input type="checkbox"/> Immunodeficiencies (frequent infections) _____ <input type="checkbox"/> Insomnia _____ <input type="checkbox"/> Frequent awakenings _____ <input type="checkbox"/> Restless legs _____ <input type="checkbox"/> Excessive daytime sleepiness _____ <input type="checkbox"/> Falls asleep inappropriately _____ <input type="checkbox"/> Excessive snoring _____ <input type="checkbox"/> Witnessed sleep apnea (stop breathing) _____
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FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	BROTHERS/SISTERS	CHILDREN
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THYROID DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BRAIN TUMORS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURES OR EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEMORY LOSS / SENILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DEMENTIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MIGRAINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEREDITARY NEUROLOGICAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Remarks / Notes _____

Doctor's Signature _____

Date _____