CENTER FOR NEUROLOGY AND STROKE CARE
Kavneet Kaur, MD MPH

577 Chestnut Ridge Rd, 2nd Floor, Suite 6, Woodcliff Lake, NJ 07677, Ph. 201.835.0729; Fax: 838.381.1796

NEW PATIENT FORM

DATE _____

NAME _____ Birth Date _____ Age_____

Requesting Physician _____ Phone # _____Fax#_____

Primary Care Physician_____Phone # _____Fax#_____

Reason for your visit today: _____

Social History Occupation: _____

Tobacco O nonsmoker O Former smoker, Quit month/year O Current smoker, How many/day? Alcohol Yes No If yes, how much and how often?

Sex (*Circle one*) M F **Marital status** (*Circle one*) Single Married Divorced Separated Widowed

Race (Please circle): Asian Native Hawaiian/Pacific islander Black/African-American White Hispanic Other

Ethnicity (Please circle) Hispanic/Latino. Not Hispanic or Latino

Drug/Food Allergies

_____

Past Medical History **O Please check this box if there is no prior medical history**

O Anxiety	O Bleeding disorder	O Back pain or injury	O Cancer _____
O Diabetes	O Depression	O Gastric reflux disease	O High blood pressure
O Heart disease	O High Cholesterol	O Migraine/headaches	O Kidney disease
O Lung disease	O Liver disease	O Parkinson's	O Rheumatoid arthritis
O Seizure	O Stroke	O Thyroid disease	O Other_____ _

Prior Surgical History **(List date of surgery in the space provided). If you had no surgeries, please check here O None**

Surgery	Date	Reason

Family Medical History

	Father	Mother	Siblings	Others (specify)
Alzheimer's				
Cancer (specify type of cancer)				
Diabetes I/II				
Heart attack				
Hypertension				
Mental illness				
Migraine				
Multiple Sclerosis				
Muscle disorder				
Parkinson's				
Seizure				
Stroke				
Other (Specify)				

Review of System: Check (□) if you had any of the following during the past **three months**?

NEUROLOGICAL		*GASTROINTESTINAL*	
Confusion		Blood in stool	
Convulsions		Decreased appetite	
Black-outs or syncope		Nausea	
Muscle twitching or cramps		Vomiting	
Stroke		HEMATOLOGIC/LYMPHATIC	
Head injury		Anemia	
Balance difficulty		Easy bruising	
Difficulty speaking		*GENITOURINARY*	
Dizziness		Difficulty urinating	
Fainting		Frequent urination	
Gait abnormality		Painful urination	
Frequent headaches		Urinary incontinence	
Tingling/numbness		*MUSCULOSKELETAL*	
Tremors		Walking difficulty	

Falls		Back pain	
Incontinence		Neck pain	
Memory loss		Muscle Cramps/Pain	
Other		Painful joints	
PSYCHIATRIC		Other	
Anxiety			
Memory loss or confusion			
Depressed mood			
Sleep problems			

Current Medications

Drug Name	Dosage	Start Date	Reason

Diagnostic studies

	CT	MRI	X-Ray	EEG	EMG	OTHER
Date						
Type						
Location						

Hospital admissions:_____

_____

The undersigned hereby authorizes the physicians of the Center for Neurology and Stroke Care to perform any diagnostic aids deemed necessary by the doctor to make thorough diagnosis of my needs. I also authorize the physicians of the Center for Neurology and Stroke Care to perform any and all forms of treatment, medical and therapy that may be indicated. I also give my consent to the Center for Neurology and Stroke Care to obtain medication information from external sources. All the information on this medical history form is correct and fully understood by me.

Name _____ Signature _____

Date _____

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REGISTRATION FORM

Date _____

PERSONAL INFORMATION

Patient's Name_____Birth Date:_____Age _____

Address: _____

Patient's Soc. Sec. Number_(Last 4 digits)__xxx-xx-_____ Email _____

Primary contact phone number _____ Alternative Number_____

Sex (*Circle one*) M F **Marital status** (*Circle one*) Single Married Divorced Separated Widowed

Emergency contact	Relationship	Phone number(s)

Occupation:_____ Employer: _____

Employer's Address: _____

INSURANCE (Please bring all insurance cards to the appointment)

Primary Insurance Company : _____Insurance co. phone_____

Insurance company address_____

Policy Holder's Name : _____Policy Holder's employer_____

Patient's relationship to Policy holder: _____Policy Number _____ Group ID_____

Secondary Insurance Co.:_____Insurance company phone_____

Insurance company address_____

Policy Holder's Name : _____Policy Holder's employer_____

Patient's relationship to Policy holder: _____Policy Number _____ Group ID_____

Pharmacy Name: _____ Address_____Ph._____

Acknowledgment of receipt of Notice of Privacy Practices of Center for Neurology and Stroke Care.

This is to acknowledge the receipt of the Notice of Privacy Practices of Dr. Kavneet Kaur P.C DBA Center for Neurology and Stroke Care.

Name _____Signature _____ Date _____

ASSIGNMENT & RELEASE: I hereby give lifetime authorization for payment of insurance benefits to be made directly to the physician for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

Name of guarantor _____Signature _____ Date _____

Communication Consent

Please check your preferred methods of communication (Please write the phone number. If no number is noted, we will use your primary/alternative numbers)

O Home phone _____ O Mobile phone _____ O Fax _____

O US Mail _____

I understand that the physicians and staff of Center for Neurology and Stroke Care may contact me to discuss clinical information related to my care. I agree that the staff and the physicians of Center for Neurology and Stroke Care may contact me via any of the methods of communication indicated above. If I do not answer the telephone, they may leave a message on my voicemail or answering machine. I agree that they may send a facsimile to the number listed above to convey information about test results, clarify medication dosages, or answer simple medical questions.

Name _____Signature _____ Date _____

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Name _____ Date of Birth_____

Current Medications

Drug Name	Dosage	Start Date	Reason

_____ _____

Signature Date