

The Neurology Center – Allen M. Lifton, M.D.
200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

RELEASE OF MEDICAL RECORDS

PATIENT: _____

DATE OF BIRTH: _____

ADDRESS: _____

City: _____ State: _____ Zip Code: _____

PHONE: _____

I hereby request that my medical records be released to:

Dr. Allen Lifton, M.D
200 Capri Isles Blvd
Suite 7D
Venice, FL 34292
Phone: (941) 485-2220
Fax: (941) 485-2150

Patient's Signature _____ Date _____

_____ Date _____

Authorized signature, if patient is unable to sign:

Relation to Patient _____

Last Name:		First Name		M.I.	Date:
DOB	SS#	Gender Male/Female	Marital status (circle one)	Single / Married / Divorced Separated / Widow/ Widower	
EMAIL:					
Florida Address:					
CITY		STATE		ZIP CODE	
Secondary Address:					
Home No:		Cell No:		Alternate No:	
Emergency Contact:			Phone No:		Relation:
Primary Care Physician:			Referring Physician:		
NOTE: IS THIS A JOB OR ACCIDENT RELATED INJURY YES NO			IF YES PLEASE PRESENT WORKER'S COMP OR AUTO INSURANCE INFORMATION.		
Primary Insurance:			Coverage Date:		Co-Pay:
Subscriber No:		Group #		Group Name:	
Subscriber Name: (if different than self)		Date of Birth		S.S. #	
Secondary Insurance:			Coverage Date:		Co-Pay
Subscriber No:		Group #		Group Name:	
Subscriber Name: (if different than self)		Date of Birth		S.S. #	
Pharmacy:			Mail-in Pharmacy:		
City:		State:		Phone No:	
				Fax No:	
<p>Note: We will bill your insurance as a courtesy to you. However, if payment is not received from your insurance company within 45 days of billing, the full payment will be expected from you. Uncovered services and/or co-pays are due at the time of service in form of cash or check only – no credit card – no debit cards</p>					
<p>Please read: I authorize payment to be made directly to Dr. Allen Lifton for services rendered. I also agree to pay any amount not approved by my insurance company. I agree to pay any collection or attorney fees that may be incurred. I authorize the release the use of this information or copies thereof to be considered as effective and valid as the original.</p>					
Signature of Patient				Date	

The Neurology Center – Allen M. Lifton, M.D.
200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

Patient's name: _____

Today's date: _____

Describe the reason for your appointment: _____

NOTE: Please list ALL medications, vitamins, herbal supplements and any over the counter medications that you are taking.

Name of Medication	Strength	Dosage	How long

List any allergies that you may have: _____

PLEASE LIST MEDICAL HISTORY: (LIST MEDICAL PROBLEMS, SURGERIES, TRAUMAS)

Patient's name: _____

Today's date: _____

NEUROLOGICAL REVIEW

- | | | |
|---|--|--|
| <input type="checkbox"/> Headache/Migraine | <input type="checkbox"/> Personality Change | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Confusion/Memory Loss | <input type="checkbox"/> Blow to head | <input type="checkbox"/> Coordination difficulty |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Facial numbness or tingling | <input type="checkbox"/> Brief paralysis |
| <input type="checkbox"/> Hallucinations/Visual disturbances | <input type="checkbox"/> Sensation of room spinning | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Concentration difficulty | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Excessive daytime sleeping | <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Headache/Tension | <input type="checkbox"/> Visual changes (blurred, diplopia, amaurosis) | |
| <input type="checkbox"/> Falling down | <input type="checkbox"/> Head injury | <input type="checkbox"/> Speech difficulty |
| <input type="checkbox"/> Cerebrovascular disease | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Trouble with smell |
| <input type="checkbox"/> Cervical spine disease | <input type="checkbox"/> Fainting | <input type="checkbox"/> Drooling |
| <input type="checkbox"/> Lumbar spine disease | <input type="checkbox"/> LOC/Concussion | <input type="checkbox"/> Dysphagia/Hoarseness |
| <input type="checkbox"/> Peripheral nerve disease | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> MS |
| <input type="checkbox"/> Decreased hearing (right/left) | <input type="checkbox"/> CNS malignancy | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> TIA/CVA | <input type="checkbox"/> Syncope | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste | |

PREVIOUS TESTING

- | | | | |
|-------------------------------------|------------|--------------|-------------|
| Have you had an MRI? _____ | Why? _____ | Where? _____ | When? _____ |
| Have you had a CT scan? _____ | Why? _____ | Where? _____ | When? _____ |
| Have you had an EEG? _____ | Why? _____ | Where? _____ | When? _____ |
| Have you had a Nerve Test? _____ | Why? _____ | Where? _____ | When? _____ |
| Have you had an EMG? _____ | Why? _____ | Where? _____ | When? _____ |
| Have you had an ECHO/Carotid? _____ | Why? _____ | Where? _____ | When? _____ |

FAMILY HISORY

Do you know of any blood relative who has or had:

- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Disease | <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Epilepsy/Seizures | |

SOCIAL HISTORY

Current job: _____ Previous job: _____

Do you smoke? _____ If yes how much? _____ Per _____

Do you drink alcohol? _____ If yes how much per week? _____

Do you drink coffee, tea or colas? _____ If yes how many cups per day? _____ per week _____

Patient's name: _____ Today's date: _____

Patient's Review of Systems – Check off any problems of conditions that you are experiencing or have experienced

Constitutional:

___ Fatigue ___ Fever ___ Loss of Appetite ___ Maximum Lifetime Weight ___ Night Sweats
___ Weakness ___ Weight Change ___ Weight Loss – Past 12 months ___ Weight Gain – Past 12 months

Allergy/Immune:

___ Colds ___ Ear fullness ___ Itchy eyes ___ Runny nose ___ Scratchy throat ___ Sinus congestion

Ophthalmology:

___ Blurry vision ___ Cataracts ___ Diminished vision ___ Discharge ___ Double vision
___ Eye irritation ___ Seasonal symptoms

Endocrinology:

___ Cold intolerance ___ Diabetes ___ Excessive sweating ___ Excessive thirst ___ Fatigue
___ Heat intolerance ___ Hot flashes ___ Sexual dysfunction ___ Frequent urination

Cardiology:

___ Chest Pain ___ Chest pain while Asleep ___ Dizziness ___ Irregular Heart Beat
___ Leg Swelling ___ Pain in legs while walking ___ Palpitations ___ Shortness of Breath
___ Varicose Veins

Gastroenterology: ___ Abdominal Pain ___ Blood in Stool ___ Change in bowel habits ___ Constipation

___ Diarrhea ___ Difficulty swallowing ___ Frequent Bloating ___ Heartburn ___ Indigestion
___ Nausea ___ Vomiting ___ Vomiting Blood

Musculoskeletal: ___ Back pain ___ Joint Pain ___ Joint Stiffness ___ Joint Swelling ___ Leg Cramps

___ Shooting Arm Pain ___ Shooting Leg Pain

Dermatology: ___ Dry//sensitive skin ___ Hives ___ Lumps ___ Rash

Neurology:

___ Balance Difficulty ___ Dizziness ___ Fainting spells ___ Falls ___ Gait abnormality ___ Headache
___ Loss of sensation in specific body area ___ Loss of strength in specific body area ___ Numbness
___ Memory Problems ___ Pain ___ Seizures ___ Tingling ___ Tremors ___ Trouble with coordination

Psychology:

___ Anxiety ___ Depression ___ Hallucinations ___ Irritability ___ Mental or Physical Abuse
___ Nightmares ___ Sleep Disturbance ___ Stress/Tension

Patient Consent to Release Mail and/or Telephone Messages

Last Name	First Name	M. I.
-----------	------------	-------

Do we have the permission to:

Send a yearly appointment reminder to your home? Y___ N___

Send test results to you home? Y___ N___

Leave the following information on your home answering machine/voice mail:

Appointment information Y___ N___

Billing information Y___ N___

Medical information Y___ N___

Leave the following information on you work answering machine/voice mail:

Appointment information Y___ N___

Billing information Y___ N___

Medical information Y___ N___

I give permission to share appointment information with the person named below:

Name: _____

I give permission to share medical information with the person named below:

Name: _____

I give permission to share billing information with the person named below:

Name: _____

Signature of Patient

Date

The Neurology Center – Allen M. Lifton, M.D.
200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA) of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (Print): _____

Signature: _____ Date: _____

Relationship to Patient: _____

Directions:

We are located in Gondola Park which is in a residential condo setting.

Driving south on 41

Take a LEFT (east) on Venice Ave.

Take a LEFT at the 3rd light (Capri Isles Blvd)

Go past the first block (Auburn Lakes) and take the next RIGHT into Gondola Park

Take an immediate RIGHT (by the mailboxes)

Go about half way down, you will see The Neurology Center on your left, Unit 7D

Our unit faces Capri Isles Blvd and the golf course.

Driving north on 41

Take a RIGHT (east) on Venice Ave.

Take a LEFT at the 3rd light (Capri Isles Blvd)

Go past the first block (Auburn Lakes) and take the next RIGHT into Gondola Park

Take an immediate RIGHT (by the mailboxes)

Go about half way down, you will see The Neurology Center on your left, Unit 7D

Our unit faces Capri Isles Blvd and the golf course.

Coming from Jacaranda area

Travel west on Venice Ave.

Turn Right at the second light from the Jacaranda round about (Capri Isles Blvd)

Go past the first block (Auburn Lakes) and take the next RIGHT into Gondola Park

Take an immediate RIGHT (by the mailboxes)

Go about half way down, you will see The Neurology Center on your left, Unit 7D

Our unit faces Capri Isles Blvd and the golf course.

Please bring and note:

- Before your appointment date, have all medical records sent to our office via fax (941)485-2150***
- Bring all medication in original bottles and/or updated list of medications.***
- Bring Identification and insurance cards.***
- Filled out forms completed prior to your appointment.***
- All co-pays and amounts not covered by insurance are due at the time of service - we only accept cash and checks (no credit cards, no debit cards)***
- Please check with your insurance company for coverage prior to your appointment to insure there has not been a recent change.***

Please check website neurologyconcerns.com for additional information.

We look forward to meeting you!