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

"Wherever the art of Medicine is loved, there is also a love of humanity" - Hippocrates

Our care begins with you.

Part of that is having a thorough medical history. So that we can best care for you, please provide us with all the required paperwork. Allen Lifton, M.D. and Brian Vereb, A.R.N.P. **need your history and forms 7 days prior to your appointment.** We thank you in advance in making sure all of your paperwork has arrived so we are fully prepared for your visit. In the event you are unable to have all of the information to us 7 days before your visit, **we will need to reschedule your appointment** and we will do our best to find a time more convenient for you and our providers.

For any cancellations, please contact our office 24 business hours prior to your appointment to avoid no-show fees.

Options for delivering your forms to us:

Mail or In–person Delivery

The Neurology Center

Allen M. Lifton, M.D. 200

Capri Isles Blvd Suite 7d

Venice, FL 34292

Please allow enough time for mail delivery and call to confirm that they were received.

Fax:

941-485-2150

Please call our office at 941-485-2220 to confirm that we have received your forms.

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Last Name		First Name	Middle Initial	Date
Date of Birth	SS#	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widower	
Email:				
Florida Address		City	State	Zip Code
Secondary Address		City	State	Zip Code
Home Number		Cell Number	Alternate Number	
Emergency Contact		Phone Number	Relation	
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 Number		Group Number	Group Name	
Subscriber Name (if different than self)		Date of Birth	SS#	
SECONDARY INSURANCE		Coverage Date	Co-Pay	
Subscriber Number		Group Number	Group Name	
Subscriber Name (if different than self)		Date of Birth	SS#	
PHARMACY / ADDRESS		CITY/STATE	PHONE NUMBER	
Mail-in Pharmacy		Telephone Number	Fax Number	
PRIMARY CARE Physician		Telephone Number	**Referring Physician** / Telephone #	

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.**

PLEASE READ: I authorize payment 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 and use of this information or copies thereof to be considered as effective and valid as the original.

Signature of Patient _____ Date _____

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

Describe the reason for your appointment:

_____
_____
_____

NOTE: LIST **ALL** MEDICATIONS, VITAMINS, HERBAL SUPPLEMENTS AND ANY OVER THE COUNTER MEDICATIONS YOU ARE TAKING.

Name of Medication	Strength	Dosage	How long

LIST ANY ALLERGIES YOU MAY HAVE: _____

_____

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

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Patient's Name: _____ Today's date: _____

NEUROLOGICAL REVIEW

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

PREVIOUS TESTING

Have you ever had any of the following tests?

TEST	WHY?	WHERE?	WHEN?
☐ MRI			
☐ CT			
☐ EEG			
☐ NERVE TEST			
☐ EMG			
☐ ECHO/CAROTID			

SOCIAL HISTORY

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

- ☐ Asthma
- ☐ Heart Problems
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Headaches
- ☐ Psych
- ☐ Blow to head
- ☐ Facial numbness or tingling
- ☐ Sensation of room spinning
- ☐ Dizziness
- ☐ Numbness
- ☐ Coordination difficulty
- ☐ Brief paralysis
- ☐ Poor balance
- ☐ Tingling

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

- ☐ Asthma
- ☐ Heart Problems
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Headaches
- ☐ Psychiatric Disease
- ☐ Migraine
- ☐ Lung Disease
- ☐ Multiple Sclerosis
- ☐ Brain Tumor
- ☐ High Blood Pressure
- ☐ Epilepsy/Seizures
- ☐ Aneurysm
- ☐ Stroke
- ☐ Thyroid

Current job: _____ Previous Job: _____

Do you smoke?	☐ Yes	☐ No	If yes, how much per day?
Do you drink alcohol?	☐ Yes	☐ No	If yes, how much per week?
Do you drink coffee, tea or colas?	☐ Yes	☐ No	If yes, how many cups per day?

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Patient's Name:_____: Date: _____

PATIENT'S REVIEW OF SYMPTOMS

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 in Past 12 Months: ☐ Weight Loss ☐ Weight Gain

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

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PATIENT CONSENT TO RELEASE AND/OR TELEPHONE MESSAGES

Last Name _____ First Name _____ Middle Initial _____

DO WE HAVE PERMISSION TO:

Send a yearly appointment reminder to your home?	☐ Yes	☐ No
Send test results to your home?	☐ Yes	☐ No

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

Appointment information:	☐ Yes	☐ No
Billing information?	☐ Yes	☐ No
Medical information?	☐ Yes	☐ No

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

Appointment information:	☐ Yes	☐ No
Billing information?	☐ Yes	☐ No
Medical information?	☐ Yes	☐ No

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

1. _____ 3. _____
2. _____ 4. _____

Signature: _____ Date: _____

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA) 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: _____

Signature of Legal Guardian: _____ Date: _____

Print Name:_____ Relationship to patient_____

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PATIENT RIGHTS AND RESPONSIBILITIES

You have the right to:

- Courtesy, kind, competent care.
- Collaborative care with your primary physician or any of your specialist. Ask questions
- An explanation of your treatment plan. Learn about your disease and options.
- Be seen within 30 minutes of your appointment time. (Every effort will be made to do so.)
- Have your phone calls returned in a timely manner. (We will make every effort to return your call within 1 business day.)
- Obtain a second opinion.
- Seek treatment elsewhere.
- Know our credentialing, scope of practice, training and education. Reasonable fee for services.
- Confidentiality and privacy of your diagnosis and care.

_____
Initial

You are responsible for:

- Notifying us if you are unable to make an appointment 24 business hours before your appointment. There is a no-show/late call fee of $95 for follow up appointments and $150 for new patients, as those times have been reserved for you.
- Giving us 2 business days for medication refill requests.
- Giving us an updated and complete (Name of RX, Dosage, Instructions) medication list that includes over the counter and herbal supplements.
- Seeking additional information on your diagnosis, medication and treatment options.
- Respect the thoughts, feelings and behavior of others you encounter in the office, including maintaining their privacy and right to confidentiality.
- Keeping your bill current and providing us with current insurance information.
- Providing us with a current and accurate address as a way to keep in touch with you beyond web encounters.
- Knowing your insurance company's plan. This includes whether our office is in network or out of network, medical coverage, prescription coverage and making sure there is a current authorization for your visit, should one be needed.

_____ _____
Print Name Date

_____

Signature

RELEASE OF MEDICAL RECORDS

PATIENT: _____

DATE OF BIRTH: (Month/Day/Year) _____

ADDRESS: _____

City: _____

State: _____

Zip Code: _____

Phone Numbers: _____

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearinghouse, insurance company to release my medical records. The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person/organization:

I hereby request that my medical records be released to:

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

Patient's Signature: _____ Date: _____

_____
Authorized signature, if patient is unable to sign:

_____
Printed Name of Guardian/Representative

Relation to Patient: _____ Date: _____