

The Neurology Center

200 Capri Isles Blvd

Phone: 941-485-2220

Suite 7D

Allen M. Lifton, M.D.

Venice, FL 34292

Fax: 941-485-2150

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

Our care begins with you.

So that we can best care for you, please provide us with all the required paperwork prior to your appointment. Our neurology office **needs your completed 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 convenient for you.

For any cancellations, please contact our office 24 business hours prior to your appointments to avoid any **no-show fees which are \$95.00 for follow-ups and \$150.00 for new patient appointments.**

We do our best to make sure that your insurance is accepted. However, to ensure that there have been no changes or something is missed, **we highly recommend that you contact your insurance company** to inquire what will be covered with our office.

To protect your privacy, we do not use email for new patient paperwork. Once you are an established patient, you may access your patient portal for information.

Please understand that **incomplete forms will create the need to reschedule your appointment.** Please check that each page is filled out COMPLETELY and ALL FORMS ARE SIGNED.

Patient Signature: _____ **Date:** _____

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.)

Last Name		First Name	Middle Initial	Date
Date of Birth	Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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	Social Security #	
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 Allen M. Lifton, M.D. for services rendered. I also agree to pay any amount not covered by my insurance company including no-show fees. 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 _____	

Patient's Name: _____ Date: _____

Describe your reason for your appointment:

List all medications, vitamins, herbal supplements and any other over the counter medications you take:

Name of Medication	Strength of each (Ex: how many mgs)	Dosage (Ex: how many per day)	How long have you been taking this?	Taking this to prevent or treat what?

ALLERGY TO:	Reaction:	ALLERGY TO:	Reaction:

SOCIAL EXPOSURE: Required to be completed *****

*Current Job/Field (s): _____

*Previous Job/Field(s): _____

LIST MEDICAL HISTORY ILLNESSES. SURGERIES AND TRAUMA

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

LIST MEDICAL HISTORY ILLNESSES, SURGERIES AND TRAUMA....continued

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

Medical Problem: _____

Approx symptom start date: _____ Is it a present medical problem? Yes: _____ No: _____

How it was treated: _____ Approx date treated: _____

Who treated you: _____ Phone: _____

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"/> Numbness |
| <input type="checkbox"/> Headache/Tension | <input type="checkbox"/> Visual changes (blurred, diplopia, amaurosis) | <input type="checkbox"/> Speech difficulty |
| <input type="checkbox"/> Falling down | <input type="checkbox"/> Head injury | <input type="checkbox"/> Trouble with smell |
| <input type="checkbox"/> Cerebrovascular disease | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Drooling |
| <input type="checkbox"/> Cervical spine disease | <input type="checkbox"/> Fainting | <input type="checkbox"/> Dysphagia/Hoarseness |
| <input type="checkbox"/> Lumbar spine disease | <input type="checkbox"/> LOC/Concussion | <input type="checkbox"/> MS |
| <input type="checkbox"/> Peripheral nerve disease | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Decreased hearing (right/left) | <input type="checkbox"/> CNS malignancy | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> TIA/CVA | <input type="checkbox"/> Syncope | |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste | |

PREVIOUS TESTING

Have you ever had any of the following tests?

TEST	WHY?	WHERE?	WHEN?
<input type="checkbox"/> MRI	_____	_____	_____
<input type="checkbox"/> CT	_____	_____	_____
<input type="checkbox"/> EEG	_____	_____	_____
<input type="checkbox"/> NERVE TEST	_____	_____	_____
<input type="checkbox"/> EMG	_____	_____	_____
<input type="checkbox"/> ECHO/CAROTID	_____	_____	_____

SOCIAL HISTORY

Have you experienced any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Psych | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Blow to head | <input type="checkbox"/> Coordination difficulty |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Facial numbness or tingling | <input type="checkbox"/> Brief paralysis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sensation of room spinning | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling |

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 | |

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? _____

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

Your Circle of Care:

Your list of those who are involved with your care.

Example: Name: Dr. Sam Smith
Category: Medical Provider
Fax #: 941-555-5555
Phone: # 941-111-2222
Relationship: **Primary doctor**

Example: Name: Jan Jones
Category: Workers Comp
Fax #: 941-622-3333
Phone: # 941-655-4444
Relationship: **Case Worker**

Name: _____ Category: _____
Fax #: _____ Phone #: _____
Relationship: _____

Name: _____ Category: _____
Fax #: _____ Phone #: _____
Relationship: _____

Name: _____ Category: _____
Fax #: _____ Phone #: _____
Relationship: _____

Name: _____ Category: _____
Fax #: _____ Phone #: _____
Relationship: _____

Name: _____ Category: _____
Fax #: _____ Phone #: _____
Relationship: _____

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: _____

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 _____

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(s). 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: _____