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

Our care begins with you.

Please fill in these forms and return them to our office so that we can schedule an appointment for you. We request these be returned to our office within 10 business days, so that your referral will stay active.

Options to deliver completed forms with signatures:

Mail, Hand Deliver or Fax to our office:

The Neurology Center/ Allen Lifton, M.D
200 Capri Isles Blvd
Suite7d
Venice, FL 34292

Phone (941) 485-2220 (*Please call to confirm hours for hand delivery)*

Fax to our office.
Fax: 941-485-2150

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

Cancellation policy: We require at least 24 business hours notification prior to your appointments for any cancellation of appointments.
No-show or late cancellation fees are $95.00 for follow-ups and $150.00 for new patient appointments.

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 delay your appointment*. Please check that each page is filled out completely and all forms are signed, including this one.

Patient Signature: ________________________________

Date: ______________________

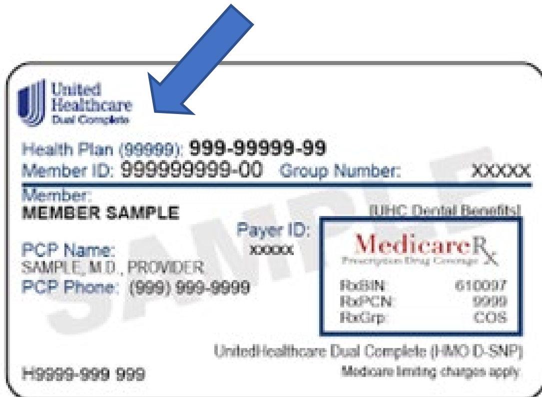
HELLO!

WE DO NOT PARTICIPATE IN THESE SPECIFIC Florida Blue and United Healthcare plans. <u>Check your card before making an appointment or filling out your paperwork.</u>

Please look at your insurance card very carefully in regard to Florida Blue and United Healthcare. These tend to be the 2 insurance types that we cannot confirm if we take without seeing the actual card. So, please check before filling out your paperwork. We do not take these particular plans of Florida Blue and United Healthcare.

We **DO NOT accept BLUE SELECT** of the Florida Blue plans. Check your card carefully for these words, typically in the righthand corner.

We **DO NOT accept United Healthcare DUAL COMPLETE**. Check your card carefully for these words, typically in small letters under United Healthcare in the left hand corner.



Patient's Name: ____

Date of Birth: ____________________________________

Email: ____

Cell Phone: ______________________________________

Emergency contact: ____

Phone number: ____________________________________

Relationship: _______________________________________

Local Pharmacy: ____________________________________

Address needed to send prescriptions to the correct location: ____________________________

____

Mail in pharmacy: ________________________________

Signature: ______________________________________ Date: ______________

Patient's Name:____Date: ___________________

Describe your reason for your appointment:

____

____

____

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

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 ********

1) **Current Job/Field: ___________________________________Previous Job/Field: ______________________________**
2) **Do you smoke**? ____ Yes ____ No **If yes**, how much per day? _______
3) **Do you drink alcohol**? ____Yes ____ No **If yes**, for how much per week? _______
4) **Do you drink coffee, tea or colas**? ____ Yes ____ No **If yes**, for how many cups per day? _______

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

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

Please list your doctors

Patient Name: ____ Date of Birth: _______________________________

Medical Doctors's name: ____

Specialty: ___________________________________

City, State ___________________________________

Medical Doctors's name: ____

Specialty: ___________________________________

City, State ___________________________________

Medical Doctors's name: ____

Specialty: ___________________________________

City, State ___________________________________

Medical Doctors's name: ____

Specialty: ___________________________________

City, State ___________________________________

Medical Doctors's name: ____

Specialty: ___________________________________

City, State ___________________________________

Medical Doctors's name: ____

Specialty: ___________________________________

City, State ___________________________________

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:

Allen Lifton, M.D.
The Neurology Center
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: ____