Our care begins with you and the information you can provide to us.

Please return these forms within 10 business days of receiving them or a call from our office giving you printing instructions from our website. Due to high demand for appointments and the need for these forms, your appointment is **subject to cancellation or rescheduling** if we do not have these completed in full and within 10 business days. Closer to your appointment time, you will also receive an electronic form that will need completion to confirm and update the information provided.

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: The patient is responsible for knowing their insurance and network status. Remember to check with your health insurance company's portal or call the number on the back of your insurance card to confirm your benefits and network status. **Make sure you input (if on portal) or tell the insurance representative (if you are calling) your policy number to get accurate information regarding your network status** as we take some insurances, but we do not take all plans within that insurance company. Your policy number is critical information to get accurate information. If you are out of network, you will be considered self-pay which is due at the time of visit. If you are in-network, we will send a claim to your insurance company and expect payment and Explanation of Benefits (EOBs) from them within 30 days. The balance will be due from you in the event your insurance company does not pay, or an Explanation of Benefits (EOBs)has been issued and an amount has been determined by your insurance company is due to our office for services rendered. Those EOBs are available to you through your insurance company and should be accessible on their portal.

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: _____

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

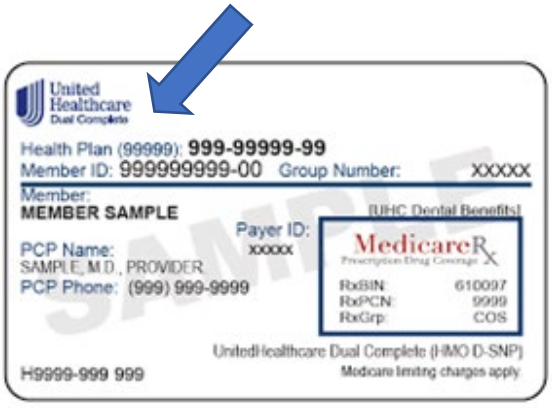
HELLO!

WE DO NOT PARTICIPATE IN THESE SPECIFIC Florida Blue and United Healthcare plans. Check your card before making an appointment or filling out your paperwork. We do not accept these specific plans and are not able to accept self-pay on these plans.

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.



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PATIENT INFORMATION

Patient's Name: _____

Date of Birth: _____

Email: _____

Cell Phone: _____

Emergency contact: _____

Cell Phone number: _____

Relationship: _____

Local Pharmacy: _____

Address needed to send prescriptions to the correct location: _____

_____

Mail in pharmacy: _____

Recent MRI/CT _____ brain ____ back/neck Facility: _____ Approx date: _____

Recent MRI/CT _____ brain ____ back/neck Facility: _____ Approx date: _____

Recent MRI /CT _____ brain ____ back/neck Facility: _____ Approx date: _____

Recent MRI /CT _____ brain ____ back/neck Facility: _____ Approx date: _____

Any other neuro scans? _____ Facility: _____

Have you had a recent hospital visit related to your visit with us _____Yes _____No

If yes, name of hospital and location: _____ Approx date: _____

Do you have a Pacemaker? _____yes _____no

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? _____

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 _____

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 Name: _____

Home Address: _____

Phone number: _____

Date of Birth: _____

Provider requesting medical records:

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

I hereby authorize any healthcare professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearinghouse, and insurance company to release all of my medical records to the above-mentioned facility and that they are authorized to receive my entire medical record, including all treatment records and diagnostic records. I understand that this authorization will allow the above-mentioned provider organization and its affiliates to use or disclose my protected health information for medical care, billing, and ordering of diagnostics, labs, insurance needs, and any other need related to my healthcare. I understand that my medical records may contain sensitive information such as mental health, HIV, AIDS, substance use disorders, sexual abuse, and/or other related conditions. I understand that these records are classified as privileged and confidential and cannot be released without my consent or the consent of a legal guardian. I also understand that should I want limited records released, I may provide that request in writing to the facility above. I understand that this request is for a release of my entire medical records for the purposes mentioned above. The signature below, including digital signatures, is to be used as authorization to release the medical records in a timely manner to The Neurology Center, Allen M. Lifton, M.D.

Signature of patient: _____

Date: _____

Legal Guardian Authorized signature
if the patient is unable to sign:_____

Printed name of Legal Guardian: _____

Relationship to patient: _____

Date: _____