# Focus Neurohealth
# New Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

| | | | | | |
|---|---|---|---|---|---|
| Residence Type: | ☐ Private Residence ☐ Nursing Home (Not a SNF) ☐ Skilled Nursing Facility or Hospice | | | | |
| Sex: | ☐ Male ☐ Female ☐ Transgender | | | | |
| Marital Status: | ☐ Single ☐ Divorced ☐ Married ☐ Partnered ☐ Widowed ☐ Legally Separated ☐ Other | | | | |
| Ethnicity: | ☐ Caucasian ☐ African American ☐ Asian/Pacific-Islander ☐ Hispanic ☐ Other | | | | |
| Employment: | ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Full-Time Student ☐ Retired | | | | |
| Employer: | | | Occupation: | | |
| SSN #: | | | Email: | | |
| Home Phone: | | Cell Phone: | | Work Phone: | |
| ☐ <u>This is my preferred number.</u><br>May we leave personal/medical information on your voicemail?<br>☐ Yes ☐ No | | ☐ <u>This is my preferred number.</u><br>May we leave personal/medical information on your voicemail?<br>☐ Yes ☐ No<br>*I understand that a cellular phone is not a secure and private line.* | | ☐ <u>This is my preferred number</u> | |

## REMINDER NOTIFICATION PREFERENCES

You will receive reminders for appointments, lab results, routine health maintenance, Rx confirmations, and general notifications based on your selection below.

☐ I wish to receive reminders via phone call (Voice)

☐ I wish to receive reminders via text message (SMS)

☐ I wish to receive reminders via phone call and text message (Voice & SMS)

## INSURANCE COVERAGE

Please ensure you **bring your photo ID and insurance card(s)** to your appointment. If your insurance requires a referral, remember it's your responsibility to obtain one from your primary care physician.

| **Primary Insurance** | |
|---|---|
| Carrier: | |
| ID#: | |
| Group#: | |
| Name of insured: | |
| Insured's date of birth: | |
| Relationship to insured: | ☐ Self ☐ Spouse<br>☐ Other: _____ |

| **Secondary Insurance** ☐ I do not have a secondary insurance. | |
|---|---|
| Carrier: | |
| ID#: | |
| Group#: | |
| Name of insured: | |
| Insured's date of birth: | |
| Relationship to insured: | ☐ Self ☐ Spouse<br>☐ Other: _____ |

Name: _____ Date of Birth: _____ Date Packet Completed: _____

## EMERGENCY CONTACTS

Please check the box below indicating whether or not you would like to have the selected contact(s) added as an authorized HIPAA contact.

| Primary Emergency Contact | |
|---|---|
| ☐ I authorize:<br>☐ I do NOT authorize: | the disclosure of my Protected Health Information (PHI) to the person listed as my Primary Emergency Contact. |
| Name: | |
| Main Phone: | |
| Work Phone: | |
| Relationship: | ☐ Spouse ☐ Partner ☐ Sibling ☐ Parent<br>☐ Child ☐ Friend ☐ Other: _____ |

| Secondary Emergency Contact | |
|---|---|
| ☐ I authorize:<br>☐ I do NOT authorize: | the disclosure of my Protected Health Information (PHI) to the person listed as my Secondary Emergency Contact. |
| Name: | |
| Main Phone: | |
| Work Phone: | |
| Relationship: | ☐ Spouse ☐ Partner ☐ Sibling ☐ Parent<br>☐ Child ☐ Friend ☐ Other: _____ |

| Primary Care Provider (PCP) | |
|---|---|
| Name: | |
| Phone: | |

| Referring Provider | |
|---|---|
| Name: | |
| Phone: | |

## HOW DID YOU HEAR ABOUT US?

☐ Physician/Provider Referral ☐ Family or Friend ☐ Website or Search Engine ☐ Other: _____

## REASON FOR VISIT

## PAST MEDICAL HISTORY (E.G. DIABETES, HIGH BLOOD PRESSURE, CANCER, ETC.)

## SURGICAL & HOSPITALIZATION HISTORY

List all surgeries, hospitalizations, and major injuries and specify the month and year they occurred.

## PREVIOUS DIAGNOSTICS & TESTING

Please list any previous imaging or diagnostic tests, including MRI, CT, EEG, and specify where they were performed.

Name:_____ Date of Birth:_____Date Packet Completed: _____

## FAMILY HISTORY

List any major illnesses in your family, including parents, grandparents, siblings, or children, (e.g. diabetes, cancer, etc.)

| |
|---|
| |

## ALLERGIES

List any allergies you have to medications

| |
|---|
| |

## PHARMACY INFORMATION

| Primary Pharmacy | | | |
|---|---|---|---|
| Type: | ☐ Local ☐ Mail-Order ☐ Specialty | | |
| Name: | | | |
| Address: | | | |
| City: | | Zip: | |
| Phone: | | Fax: | |

| Secondary Pharmacy | | | |
|---|---|---|---|
| Type: | ☐ Local ☐ Mail-Order ☐ Specialty | | |
| Name: | | | |
| Address: | | | |
| City: | | Zip: | |
| Phone: | | Fax: | |

## CURRENT MEDICATIONS

List all medications you are currently taking, including prescribed, over-the-counter, and herbal supplements.

| Medication | Start Date | Dose/Frequency | Prescribing Physician | Comments |
|---|---|---|---|---|
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