Tallahassee Neurology Specialists, P.L.
ROLAND P. JONES, M.D. Neurology & Pain Management
1842 Jaclif Court, Suite B •Tallahassee, FL 32308 Telephone: (850) 765-8623 • Fax: (850) 765-0118

ROLAND P. JONES, M.D.
BOARD CERTIFIED PAIN MANAGEMENT & NEUROLOGY
SPECIALIZING IN MULTIDISCIPLANRY & INTERVENTIOANL
PAIN MANAGEMENT

THANK YOU FOR CHOOSING TALLAHASSEE NEUROLGY SPECIALISTS FOR YOUR NEUROLOGY AND PAIN MANAGEMENT NEEDS. PLEASE TAKE A FEW MINUTES TO COMPLETE THE ATTACHED PAPERWORK. YOU MAY BRING THE PAPERWORK TO YOUR APPOINTMENT WITH YOU OR SEND IT IN AHEAD OF TIME.

PLEASE BRING THE FOLLOWING WITH YOU:

1). YOUR COMPLETED NEW PATENT PAPERWORK
2). INSURANCE CARDS
3). A PICTURE I.D.
4). ANY RECENT MRI/CT FILMS/TEST

*****PLEASE ARRIVE 30 MINUTES EARLY FOR YOUR APPOINTMENT*****

FAILURE TO COMPLY WITH THIS REQUEST MAY RESULT IN DELAY IN YOUR APPOINTMENT OR YOU MAY NOT BE SEEN AT ALL.

****** IF YOU HAVE TO CANCEL PLEASE CONTACT US 24 HOURS BEFORE YOUR SCHEDULED APPOINTMENT OR IT WILL BE CONSIDERED A NO SHOW APPOINTMENT (YOU MAY BE CHARGED A NO SHOW FEE)******

IF YOU HAVE ANY QUESTIONS OR CONCERNS PLEASE CALL OUR OFFICE AT 850-765-8623

THANK YOU FOR YOUR COOPERATION

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New Patient Information

Patient Name (Last) _____, (First) _____DOB: _____

Parent or Legal Guardian Name (if minor): _____

Address: _____ City/State: _____-_____ Zip: _____

Phone (H) _____ (W) _____ (C) _____

Email Address: _____

SSN#: _____ Preferred Contact Method: _____

Marital Status: _____ Race: _____ Ethnic Group: _____

Referring Doctor: _____ Primary Doctor: _____

Insurance:

***Primary Insurance Company: _____**

ID #: _____ Group #: _____

****Secondary Insurance Company: _____**

ID #: _____ Group #: _____

******* Is this related to an Auto or Workers Comp Injury? _____** ***If yes complete the following: ***********

Date of Injury: _____ CL# _____

Adjuster Name and Number: _____

Current or Previous Litigation? _____

Attorney Name and Phone Number: _____

Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____

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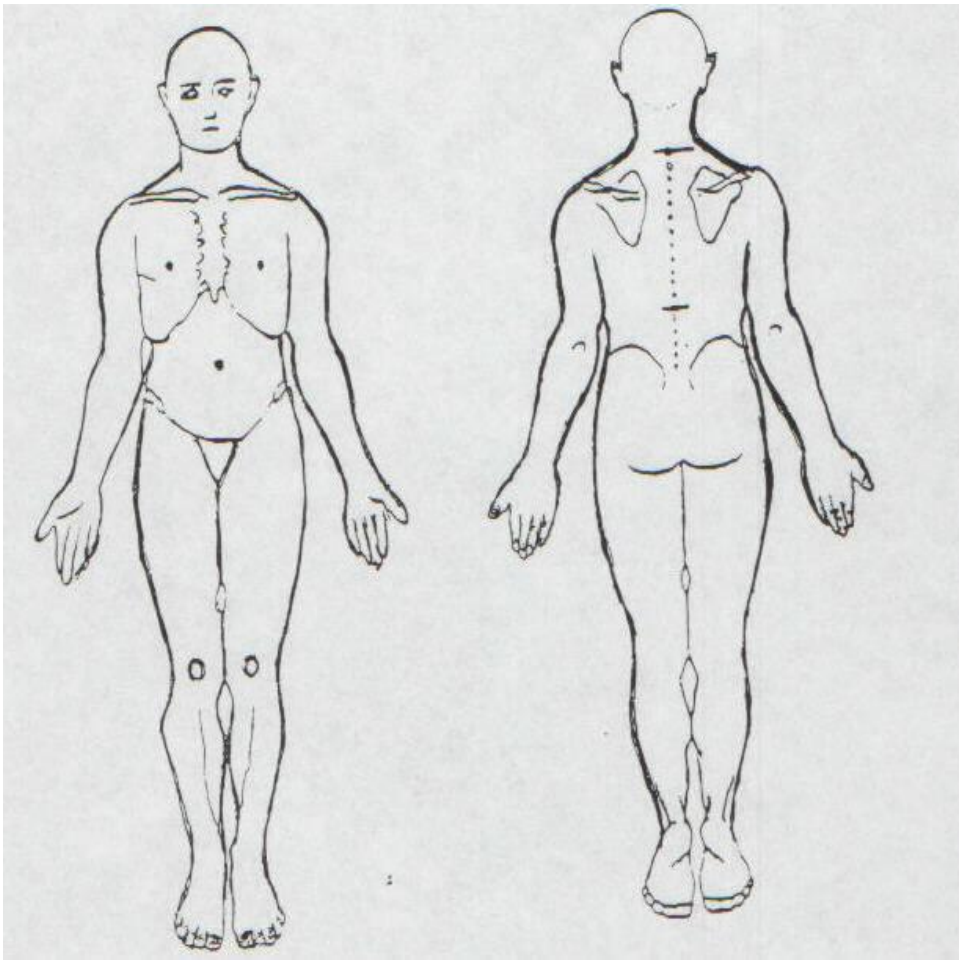
Patient Name: _____ ***DOB:*** _____

****Please mark the body below with the appropriate symbol according to your pain*.***

Aching ▶ Numbness = Pins & Needles O Burning X Stabbing + Radiates



How long have you had this pain? _____

Is your pain constant or does it come and go? _____

What do you believe is the cause of your pain? _____

Did your pain begin gradually or abruptly? _____

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Patient Name: _____ ***DOB:*** _____

Daily Functioning: Please check if any of the following increases or decreases your pain.

Action	Increases	Decreases	No Change
Eating			
Cold			
Damp			
Weather Changes			
Physical Activity			
Massage			
Pressure			
Movement			
Sleep or Rest			
Lying Down			
Sitting			
Standing			
Distraction (TV, Crafts, Etc.)			
Urination			
Bowel Movement			
Tension			
Bright Lights			
Loud Noises			
Fatigue			
Sneezing/Coughing			
Riding in a Car			
Walking			

Daily Functioning: Please check how your pain has interfered with your daily functioning.

	None	A Little	Some	A Lot
General Activity				
Walking Ability				
Normal Work Routine				
Relations with Other People				
Sleep				
Enjoyment of Life				
Ability to Concentrate				
Appetite				

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Patient Name: _____ ***DOB:*** _____

Pain Scale: Use the following scale to indicate how severe you pain is. 0= no pain, 10= the worst pain (ex: being on fire while completely awake)

Your pain at its WORST	0	1	2	3	4	5	6	7	8	9	10
Your pain at its LEAST severe	0	1	2	3	4	5	6	7	8	9	10
Your pain on AVERAGE	0	1	2	3	4	5	6	7	8	9	10
Your pain at the PRESENT TIME	0	1	2	3	4	5	6	7	8	9	10
What level of pain do you think you could function with on a daily basis?	0	1	2	3	4	5	6	7	8	9	10

Prior Treatments: Please check any of the following treatments you have had for this pain problem. Include date and results. Check all that apply.

Date(s)	Treatment	Improved	Not Improved
	Epidural Steroid Injection in a Pain Clinic		
	TENS unit		
	Physical Therapy		
	Traction		
	Acupuncture		
	Chiropractic		
	Psychiatrist/ Psychologist		
	Alternative Medical Treatment		
	Surgery		
	Other Pain Clinic		

Past/Current Medical History of yourself and family: Please check ALL that apply

	Self	Family		Self	Family		Self	Family
Alcoholism			Heart Disease			Osteoporosis		
Anemia			Hepatitis			Phlebitis		
Arthritis			High BloodPressure			S.T.D.		
Asthma			High Cholesterol			Stroke		
Cancer/Tumor			HIV/ Immune Dx			Suicide Attempt		
Diabetes			Kidney Disease			Thyroid Disease		
Drug Abuse			Liver Disease			Tuberculosis, TB		
Depression			Lung Disease			Ulcer		
Epilepsy/Seizure			Mental Illness			Cardiac Stents		
Glaucoma			Osteoarthritis					

Surgical History: _____

_____

_____

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Social History:

Tobacco Use: Yes / No **If yes how much?** _____/ per day, _____/ per week

Alcohol Use: Yes/ No **If yes how much?** _____/ per day, _____/ per week

How much caffeine do you consume per day? ___ 1-2/day ___3-5/day ___6 or more/day ___none

Have you ever used illegal drugs for recreational or pain control? Yes/ No

Have you ever abused prescription medications? Yes/ No If yes, what**? _____**

Are you currently in or ever attend substance abuse program? Yes/ No If yes, when? **_____**

Are you currently employed? Yes/ No **Occupation: _____**

If no reason for non-employment: _____

If Female: Last Period: _____ possibility of being pregnant? Yes/ No

Date of Hysterectomy: _____ Date of Menopause: _____

Is there any history of sexual abuse/ assault? Yes/ No **If yes, when? _____**

Allergies: Please list any MAJOR allergies that you have with the reaction to them.

Allergy	***Reaction***

Medication List: ***Check here if attaching list _____***

Medication:	***Dosage:***	***Frequency:***	***Doctor Prescribed***

Are you currently taking Blood Thinners: Yes/ No If yes, what and why? **_____**

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Review of Systems:

GENERAL ☐ Healing Problems ☐ Fever ☐ Weight Loss ☐ Muscle Aches ☐ Current Infection or Ulcer	**CARDIOVASCULAR** ☐ Chest Pain Recently ☐ Heart Attack ☐ Congestive Heart Failure ☐ High Blood Pressure ☐ Claudication/Cramping With Walking ☐ Leg Swelling ☐ History of Cardiac Stents:_____
EAR NOSE & THROAT ☐ Vertigo ☐ Headache ☐ Glaucoma ☐ Visual Disturbances ☐ Jaw Pain	**SKELETAL** ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Gout ☐ History of Orthopedic or Spinal Surgery ☐ Inflamed, Swollen, or Painful Joints:_____ ☐ History of Joint Replacement:_____
NECK ☐ Stiff Neck ☐ Neck Pain ☐ Swollen Lymph Nodes ☐ History of Neck Surgery	**GASTROINTESTINAL** ☐ Stomach or Intestinal Ulcer ☐ Acid Reflux ☐ History of Stomach Surgery ☐ Constipation ☐ Incontinence (fecal) ☐ Recent Change in Bowel Habits
PSYCHIATRIC ☐ Depression/ Anxiety ☐ History of Addiction or Substance Abuse ☐ Insomnia ☐ History of Rape or Sexual Assault ☐ History of Psychiatric Hospitalization ☐ History of Psychiatric Counseling	**GENITOURINARY** ☐ Venereal Disease ☐ Flank Pain ☐ Pain with Urination ☐ Erectile Dysfunction ☐ Incontinence (urine) ☐ Change in Bladder Habits
NEUROLOGIC ☐ Numbness:_____ ☐ Weakness:_____ ☐ Worsening Coordination/Clumsiness ☐ Seizures ☐ Stroke or Transient Ischemic Attack ☐ Headaches ☐ Other Neurological Illness :_____	**HEMATOLOGIC** ☐ Severe Anemia ☐ Abnormal Bleeding ☐ Currently on Coumadin, Plavix, or other Blood Thinners ☐ History of dangerous blood clots or embolism
RESPIRATORY ☐ COPD ,Emphysema, Asthma or Chronic Bronchitis ☐ Chronic Cough ☐ Chronic Shortness of Breath ☐ Sleep Apnea ☐ Tuberculosis	**SKIN** ☐ Current Rash ☐ Current Ulcer ☐ Skin Cancer ☐ New Abnormal Skin Growth ☐ History of Shingles
ENDOCRINE ☐ Excessive Thirst ☐ Diabetes ☐ Recent Change in Appetite ☐ Thyroid Problems	**OTHER** ☐ Are there any other new symptoms that you wish to tell us about? : _____ _____

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Acknowledgement of Privacy Statement, Authorization and Assignment of Benefits

Patient Name: _____ Date: _____
Parent or Legal Guardian Name: _____ Date: _____
(If patient is minor or dependent)

Privacy Statement

I acknowledge receipt of the **Notice of Privacy Practices** from Tallahassee Specialists, P.L. I understand that it is my responsibility to read the information provided therein.
Signature: _____ Date: _____
(If patient is a minor or dependent, parent or legal guardian must sign)

Release of Medical Information

Should it become necessary, Tallahassee Neurology Specialists, P.L. Physicians and medical staff have my permission to discuss and release my health information, including test results, with the individuals listed below. The people that are listed below are also authorized to schedule, cancel, or reschedule appointments and pick-up prescriptions. **Any changes to this information must be made in writing to Tallahassee Neurology Specialists, P.L.**

1. **Name: _____ Relationship: _____**
   Phone: _____
2. **Name: _____Relationship: _____**
   Phone: _____
3. **Name: _____Relationship: _____**
   Phone: _____

Authorization and Assignment of Benefits

I authorize the release of any medical or other information necessary to process the insurance claim(s) for services rendered by Tallahassee Neurology Specialists, P.L. I request payment of government benefits, if applicable, to the party who accepts assignment. I authorize payment of medical benefits to Tallahassee Neurology Specialists, P.L. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered.
Signature: _____ Date: _____
(If patient is a minor or dependent, parent or legal guardian must sign)

Payment Policy

I understand that all copays and/or co-insurances are due at the time of service. If I do not have my copayment or co-insurance for a visit then I understand that Tallahassee Neurology Specialists, P.L. has the right to reschedule my appointment.
Signature: _____ Date: _____
(If patient is a minor or dependent, parent or legal guardian must sign)

Treatment Authorization

The undersigned herby consents to evaluation or treatment the assigned healthcare provider may deem necessary to patient named above
Signature: _____ Date: _____
(If patient is a minor or dependent, parent or legal guardian must sign)

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AUTHORIZATION FOR RELEASE OF

PROTECTED HEALTH INFORMATION

Patient's Name:

Last: _____ First: _____Middle: _____

Patient's Address: _____City: _____State: ___Zip:_____

Date of Birth: _____ Phone Numbers: _____

Person or Facility To RELEASE Information:

Name: _____

Address: _____

City: _____State: _____Zip: _____

Phone: _____Fax: _____

Person or Facility To RECEIVE Information:

Name: _____

Address: _____

City: _____State: ____Zip: _____

Phone: _____Fax: _____

*I understand if I consent to the release of any medical records, the result of any HIV Antibody Testing is included in the medical records._____ (INITIAL)

PURPOSE: ☐ Changing Physicians, ☐ Personal Copy, ☐ Attorney, ☐ Insurance, ☐ Other

This Authorization Will Expire On: _____ (If no date specified, it will expire 60 days after date signed)

Signature of Patient/Legal Guardian: _____ Date: _____