The Nerve and Muscle Center of Texas

DEMOGRAPHIC INFORMATION FORM

(Please Print Clearly)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	MI:	Birth date:	Sex:	Social Security no.:

Mailing Address	Street	City	State	ZIP

Home Phone:	Cell Phone:	Email Address	Marital status:

Spouse's name	Spouse's date of birth	Spouse's Cell Phone

Patients employer	Spouse's employer
Patients business address	Spouse's business address
City, State, and ZIP	City, state, and Zip
Patients business phone	spouse's business phone

Who referred you to our center (Please check one box):	☐ Dr.	Dr's Phone
Dr's Address:		☐ Internet

☐ Family	☐ Friend	☐ Close to home/work	☐ Hospital	☐ Other

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
Address	City	state	zip

I hereby consent to treatment. I authorize HOUSTON NEUROCARE, P.A. to release all medical information (including but not limited to, psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third party payors. I authorize HOUSTON NEUROCARE, P,A., to release all medical information to my referring physician and my primary (family) physician. I authorize HOUSTON NEUROCARE, P.A. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrators to release such information to HOUSTON NEUROCARE, P.A. I agree that these provisions will remain in effect until I provide written revocation to HOUSTON NEUROCARE, P.A. I assign benefits payable to HOUSTON NEUROCARE, P.A. for medical services rendered to myself and/or dependents. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Patient/Guardian signature *Date*

HOUSTON NEUROCARE, P.A.
NERVE AND MUSCLE CENTER OF TEXAS
AZIZ SHAIBANI, M.D.

PRIVACY PRACTICES ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have been given an opportunity to request or review a copy of our *Notice of Privacy Practices (***https://www.nerveandmuscle.org/privacy-practices***)* which describes how medical information about you may be used and disclosed and how you can get access to that information.

If you have any specific restrictions you would like to place on the use and/or disclosure of your information, please list below:

____

____

____

____

____

Patient Name: ____
(Please Sign Name)

Patient Date of Birth: __________________________________

August 2020

Authorization For The Use And/Or Disclosure Of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization (please check all that apply):

   DISCHARGE SUMMARIES
   PROGRESS NOTES
   MEDICATIONS
   HISTORY AND PHYSICAL EXAMS
   LAB REPORTS

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

(TEL):	(FAX):

3. I authorize the following persons (or class of persons) to receive my protected health information:

   AZIZ SHAIBANI, MD, FACP, FAAN
   NERVE AND MUSCLE CENTER OF TEXAS
   (TEL) 713-795-0033 (FAX) 877-935-8122

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires ____

7. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Houston Neurocare, P.A., nor will it affect my eligibility benefits.

9. My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):

   DOB:

I certify I have received a copy of the authorization.

SIGNATURE DATE

PRINT NAME RELATIONSHIP TO PATIENT

OR

NAME OF PERSONAL REPRESENTATIVE

PATIENT HISTORY

NAME ______________________________ DATE ______________

OCCUPATION ______________________________

RACE ______________ PRIMARY LANGUAGE ______________

HEIGHT _____ Ft _____ In WEIGHT ______________

PRESENT COMPLAINTS | HOW LONG THEY HAVE BEEN PRESENT:

______________________ | ______________

______________________ | ______________

______________________ | ______________

PAST HISTORY - PLEASE LIST ANY MAJOR ILLNESSES: (use last page if space is not enough)

____

CURRENT MEDICATIONS WITH STRENGTH AND DOSE: (use last page if space is not enough)

1.______________________ 2.______________________

3.______________________ 4.______________________

5.______________________ 6.______________________

PLEASE LIST DRUG/FOOD/ENVIRONMENTAL ALLERGIES:

DO YOU HAVE OR HAVE YOU HAD (Check the right boxes) HIGH BLOOD PRESSURE DIABETES STROKE

CANCER NEUROPATHY

PAST SURGERIES (INCLUDING NECK OR BACK SURGERY):

HAVE YOU EVER HAD A CAT SCAN, MRI OR MYELOGRAM? IF YES, LIST DATE AND LOCATION:

DO YOU SMOKE: (PLEASE CIRCLE ONE) YES NO IF YES, HOW MANY PACKS/DAY ______________

DO YOU DRINK ALCOHOL (PLEASE CIRCLE ONE) YES NO IF YES, HOW MANY DRINKS PER

ARE YOU MARRIED (PLEASE CIRCLE ONE) YES NO NUMBER OF CHILDREN MALE_______FEMALE________

PATIENT'S NAME ____

HAVE ANY OF YOUR ***CHILDREN*** SUFFERED A NEUROLOGICAL ILLNESS (PLEASE CIRCLE ONE) YES NO

IF YES, PLEASE EXPLAIN____

NUMBER OF SIBLINGS: Brothers ________Sisters ________

DO ANY OF YOUR ***FAMILY*** MEMBERS HAVE:

HIGH ARCHED FEET (PLEASE CIRCLE ONE) YES OR NO
FLAT FEET (PLEASE CIRCLE ONE) YES OR NO
EXERCISE INTOLERANCE (PLEASE CIRCLE ONE) YES OR NO
TROUBLE WALKING (PLEASE CIRCLE ONE) YES OR NO
MUSCLE DISEASE (PLEASE CIRCLE ONE) YES OR NO
DIABETES (PLEASE CIRCLE ONE) YES OR NO
NEUROPATHY (PLEASE CIRCLE ONE) YES OR NO

OTHER (PLEASE SPECIFY OTHER DISORDERS)

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS/COMPLAINTS?

	YES	NO	DESCRIBE IF NEEDED
POOR COORDINATION			____________________
MUSCLE CRAMPS			____________________
MUSCLE WEAKNESS			____________________
LOSS OF CONTROL OF ARMS OR LEGS			____________________
LOSS OF MUSCLE BULK			____________________
MUSCLE PAIN			____________________
EXERCISE INDUCED MUSCLE CRAMPS			____________________
CHANGE IN URINE COLOR AFTER EXCERCISE			____________________
DIFFICULTY CLIMBING STAIRS			____________________
DIFFICULTY RISING FROM DEEP CHAIR			____________________
BLURRED VISION			____________________
DOUBLE VISION			____________________
DROOPY EYELIDS			____________________
PAIN BEHINE THE EYES			____________________
FATIGABILITY OF JAW MUSCLES			____________________
HOARSENESS			____________________
GENERALIZED FATIGUE			____________________
SLURRED SPEECH			____________________
DIFFICULTY SWALLOWING			____________________
SHORTNESS OF BREATH			____________________
CONVULSIONS			____________________
NUMBNESS			____________________
TINGLING			____________________
NECK PAIN			____________________
BACK PAIN			____________________
ARM PAIN			____________________

PATIENT'S NAME ____

LEG PAIN	______________________
FEET PAIN	______________________
SHOULDER PAIN	______________________
STIFFNESS	______________________
HEARING LOSS	______________________
APETITE CHANGES	______________________
WEIGHT LOSS	______________________
INSOMINA	______________________
ANXIETY	______________________
DEPRESSION	______________________
COUGH	______________________
FEVER	______________________
CHILLS	______________________
NIGHT SWEATS	______________________
PROFUSE SWEATING	______________________
WHEEZING	______________________
CHEST TIGHTNESS	______________________
PALPITATIONS	______________________
CHEST PAIN	______________________
URINARY FREQUENCY	______________________
POOR CONTROL OF BLADDER	______________________
CONSTIPATION	______________________
DIARRHEA	______________________
NAUSEA	______________________
VOMITING	______________________
SKIN RASH	______________________
DIZZINESS	______________________

DO YOU HAVE AN ADVANCED MEDICAL DIRECTIVE? YES OR NO

I agree this information is correct ______________________________

Patient's signature

PLEASE USE THIS SPACE TO TELL US MORE ABOUT MEDICATION, SURGERIES OR MEDICAL HISTORY IF THE SPACE ABOVE WAS NOT ENOUGH