Tulane DOCTORS
Healing People.
Defining Medicine.

Patient Name: _____

Address: _____
Street City State Zip Code

Primary Phone #:_____ ☐Home ☐Cell ☐Other _____

Secondary Phone # _____ ☐Home ☐Cell ☐Other _____

Date of Birth: _____ **Gender:** ☐Female ☐Male **Age:** _____ **Race:** _____

Marital Status: _____ **Patient's Social Security #:** _____

e-mail address: _____

Referring Physician: _____ **Phone #:** _____

Patient's Employer: _____ **Occupation:** _____

Employer's Address: _____

Employment Status: ☐Full Time ☐Part Time ☐Self Employed ☐Retired

Pharmacy Name: _____ **Phone Number:** _____

Pharmacy Address: _____

Next of Kin/Emergency Contact Information

Name: _____ **Relationship:** _____

Address: _____

Primary Phone #:_____ ☐Home ☐Cell ☐Other _____

Secondary Phone # _____ ☐Home ☐Cell ☐Other _____

PLEASE HAVE YOUR INSURANCE CARD AND PHOTO ID AVAILABLE TO COPY

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Arrival Notice

All patients must arrive 10-15 minutes before scheduled appointment time for completion of new patient information. Patients that show up 15 minutes past your scheduled appointment time will result in the rescheduling of your appointment.

MRIs

If an MRI is required for your visit, you must have the correct disc and MRI report with you to be checked in and seen. If disc is not present, your appointment will be rescheduled.

Thank you for your understanding and for choosing Tulane Neurosciences for your medical needs.

TULANE UNIVERSITY DEPARTMENT OF NEUROLOGY
NEW PATIENT QUESTIONNAIRE

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **HEIGHT:** _____ **WEIGHT:** _____
MO DAY YEAR

REASON FOR THE VISIT: _____ **PAST**

MEDICAL HISTORY: Please circle

Heart Attack	Cancer	Hearing Loss	Alcoholism	High Cholesterol	Anemia	Please List other Medical Problems Below:
Migraines	Glaucoma	Arthritis	Kidney Disease	Liver Disease	Depression	
High Blood Pressure	Bleeding Problems	Thyroid Disease	Blood Clots	Diabetes	Anxiety	
Asthma/ COPD	Stroke	Osteoporosis	Kidney Stones	Stroke	HIV	

FAMILY HISTORY:

FAMILY MEMBER	AGE	IF NOT ALIVE, WHAT WAS AGE OF DEATH?	HEALTH PROBLEM OR CAUSE OF DEATH
MOTHER			
FATHER			
SISTER(S)			
BROTHER(S)			
CHILDREN			

VACCINATIONS:

FLU- Y/N DATE OF LAST IMMUNIZATION: _____ PNEUMONIA -Y/N DATE OF IMMUNIZATION: _____

ALLERGIES: _____

SURGICAL HISTORY and DATES:

1._____ 2._____

3._____ 4. _____

DO YOU SMOKE? YES NO IF YES, HOW MANY CIGARETTES DO YOU SMOKE PER DAY? _____
DO YOU CONSUME ALCOHOL/BEER? YES OR NO IF YES, HOW MANY DRINKS DO YOU HAVE PER DAY? _____

DO YOU HAVE ANY WEAKNESS? ☐ YES ☐ NO IF YES, WHERE? _____

DO YOU HAVE ANY NUMBNESS? ☐ YES ☐ NO IF YES, WHERE? _____

MARK THE TREAMENTS YOU HAVE TRIED- PLEASE CIRCLE

PHYSICAL THERAPY	BRACING	IBUPROFEN/ADVIL	OTHER MEDICATIONS	INJECTIONS
CHIROPRACTOR	ACUPUNCTURE	SURGERY	BED REST	PAIN CLINIC
INJECTIONS	RHIZOTOMY	EXERCISE THERAPY		

REVIEW OF SYSTEMS: Have you recently had these conditions in the last few weeks? Circle Yes or No

GENERAL				GI		
Weight loss?	YES	NO		Constipation	YES	NO
Weight gain?	YES	NO		Diarrhea	YES	NO
Fatigue?	YES	NO		Abdominal pain	YES	NO
Abnormal sweating?	YES	NO		Nausea	YES	NO
Insomnia	YES	NO		Vomiting	YES	NO
EYES				GU		
Blurry vision	YES	NO		Pain with urination?	YES	NO
Double vision	YES	NO		Frequent urination?	YES	NO
Problems looking up or down	YES	NO		Erectile dysfunction	YES	NO
Light sensitivity?	YES	NO		Incontinence when laughing/sneezing?	YES	NO
HEENT				Frequent urinary tract infection?	YES	NO
Problems swallowing?	YES	NO		Full bladder incontinence?	YES	NO
Softening of the voice?	YES	NO		Partial dribbling incontinence?	YES	NO
Hard of hearing?	YES	NO		MSK		
Ear fullness?	YES	NO		Joint pain	YES	NO
Ringing of the ears?	YES	NO		Joint swelling	YES	NO
RESPIRATORY				Lower back pain	YES	NO
Cough	YES	NO		Neck pain	YES	NO
Wheezing	YES	NO		Muscle stiffness	YES	NO
Shortness of Breath	YES	NO		Always have cold hands/feet?		
CARDIOVASCULAR				SKIN	YES	NO
Heart racing/palpitations?	YES	NO		Mouth ulcers	YES	NO
Swelling in the legs?	YES	NO		Genital ulcers	YES	NO
NEUROLOGIC				Rashes		
Headaches	YES	NO		Abnormal moles	YES	NO
Memory problems	YES	NO		PSYCH	YES	NO
Balance problems	YES	NO		Crying Spells	YES	NO
Weakness in arm or leg	YES	NO		Depression	YES	NO
Muscle slowness	YES	NO		Suicidal thoughts	YES	NO
Coordination problems	YES	NO		Obsessive Compulsive Behaviors	YES	NO
Loss of sensation	YES	NO		Paranoia		
Tremor	YES	NO		Anxiety	YES	NO
Seizures	YES	NO		Hallucinations	YES	NO

HAVE YOU EVER BEEN ON ANY OF THE DRUGS LISTED BELOW? Circle the ones you have been on.

Zyprexa	Olanzapine	Reglan	Metoclopramide	Thorazine	Chlorpromazine
Geodon	Ziprasidone	Compazine	Prochlorperazine	Prolixin	Fluphenazine
Haldol	Haloperidol	Phenergan	Promethazine	Orap	Pimozide
Risderdal	Risperidone	Abilify	Aripiprazole		

List any previous Neurologists: _____

**If possible, please bring old medical records from previous neurology visits, a CD of any old MRIs of the Brain/Spine, or any other records relating to your neurologic condition to the clinic visit.

Primary Care Physician: _____

Any other Physician(s) you would like us to fax the results of this visit to:_____

PLEASE LIST ALL OF THE MEDICATIONS AND YOU ARE CURRENTLY TAKING INCLUDING VITAMINS AND OVER THE COUNTER DRUGS:

_____

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Tulane University Medical Group
CONSENT AND RELEASE

ASSIGNMENT OF BENEFITS: I authorize direct payment to Tulane University Medical Group (TUMG), of all medical benefits, settlements, or judgments applicable to my treatment by TUMG physicians and other clinicians at the hospital or clinic. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked in writing by me. I understand that I am personally responsible for payment of all fees applicable to my treatment by TUMG physicians at the hospital or clinic, including copayments, deductibles, and fees for non-covered services, irrespective of other insurance coverage or other parties' responsibility to me for such fees. If unpaid balances are overdue and are referred for collection, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with collection.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, ACCEPTS THE TERMS THEREOF, AND HAS RECEIVED A COPY THEREOF.

RELEASE OF INFORMATION: I authorize TUMG and/or its physicians and other clinicians to disclose all or part of my medical or billing records to any insurance carrier or persons employed by such carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to group health plans for group insurance coverage, workman's compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release TUMG and its physicians and clinicians from any and all responsibility relative to the release of such information. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records: decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

_____ PATIENT NAME

_____ DATE OF BIRTH

_____ PATIENT SIGNATURE

_____ NAME OF AUTHORIZED AGENT, IF ANY

_____ SIGNATURE – IF SIGNED BY AUTHORIZED AGENT

_____ RELATIONSHIP TO PATIENT

_____ WITNESS NAME

_____ WITNESS SIGNATURE

_____ DATE OF SIGNING TIME

RX ELIGIBILITY CONSENT - By signing this consent form you are agreeing that Tulane University Medical Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I hereby provide informed consent to Tulane University Medical Group to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

INITIAL _____

CONSENT FOR TREATMENT DATE _____ TIME _____

I, OR _____ FOR _____ KNOWING THAT (I AM/HE OR SHE IS) SUFFERING FROM A CONDITION REQUIRING DIAGNOSIS AND/OR MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND HOSPITAL, MEDICAL, AND SURGICAL CARE AS NECESSARY IN THE JUDGMENT OF PHYSICIAN(S) IN CHARGE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE ME AS TO THE RESULTS OF EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE TULANE UNIVERSITY MEDICAL GROUP TO RETAIN OR DISPOSE OF ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY DURING MY TREATMENT, AND TO USE SUCH SPECIMENS OR TISSUES FOR SCIENTIFIC, EDUCATIONAL, OR RESEARCH PURPOSES, TO THE EXTENT THAT SUCH SPECIMENS AND TISSUES ARE NOT KEPT AT TULANE UNIVERSITY HOSPITAL AND CLINIC.

WITNESS _____ SIGNATURE _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

REFUSAL OF CONSENT FOR TREATMENT

I, _____ REFUSE TO CONSENT TO _____

_____ UPON _____

_____ I HAVE BEEN ADVISED OF THE CONSEQUENCES AND RISKS OF SUCH REFUSAL, AND HEREBY RELEASE THE PHYSICIANS, CLINICIANS, AND TULANE UNIVERSITY MEDICAL GROUP FROM LIABILITY FOR INJURIES ARISING FROM SUCH REFUSAL.

WITNESS _____ SIGNATURE _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

Tulane Neurosciences

101 Judge Tanner Blvd., Suite 402
Covington, LA 70433
Office: 985-951-3222

For your safety, our policy on authorizing the continuation of prescription medication is as follows without exception:

1. We only refill medications prescribed by physicians or physician assistants in this clinic. We will not authorize prescriptions by another physician.
2. We will not refill a prescription if you have not had an appointment within the last three months. Reasons for this policy include but are not limited to:
    a. We must be able to monitor your progress and response to medication on a regular basis to determine if the dose is appropriate for maximum effectiveness and safety.
    b. The Food and Drug Administration (FDA) may have discovered new potential toxicities or changed dosing recommendations or new studies may suggest a new approach.
3. It is important to report all medications you are taking to every provider you see to avoid potential drug interactions or organ damage. Carrying a medication list with you is a good idea.
4. It is your responsibility to notify your pharmacy for refills prior to running out. The pharmacy will need to send notification of your request for a refill via fax to our office at 504-503-7002 or e-scribe. Please allow 3 business days for your request to be processed.
5. NO narcotic refills will be authorized by our physicians or physician assistants after the 2 week postoperative period. If you continue to need pain medication after this period, you will be asked to provide the name of a pain management physician of your choice and a referral will be sent if needed.
6. As of October 1, 2014, the DEA requires that a hard copy prescription for a narcotic be written. Narcotic prescriptions cannot be faxed or called into a pharmacy.

Please acknowledge that you have read and understand the above policy on narcotic medication:

_____ _____
Patient's signature Date

_____
Please print patient's name

_____ _____
Witness (Neurosciences staff) Date

Tulane University Medical Group

Notice of Privacy Practices

I hereby acknowledge that I received a copy of the Tulane University Medical Group Notice of Privacy Practices.

Signature_____Date_____

Print Patient's Name_____

If not signed by the patient, please indicate relationship:_____

Print Name_____ Witness_____

Tulane University Medical Group

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Tulane University Medical Group must obtain a written authorization from a patient or their Personal Representative prior to releasing Protected Health Information, unless a legal exception applies. This form must be fully and completely filled out to be valid. A reasonable copying and handling charge may be charged for this request pursuant to La. R.S. 40:1165.1.

PATIENT AND RECIPIENT'S INFORMATION

I hereby authorize Tulane University Medical Group to release Protected Health Information on the patient listed below.

THE RECORDS OF: *(Patient's Information)*

Name: _____

DOB (MM-DD-YYYY): _____

Address: _____

Phone: _____

DELIVER TO: *(Recipient's Information)*

Name: _____

Address: _____

Phone: _____

Fax: _____

PURPOSE OF DISCLOSURE

☐ Treatment ☐ Personal ☐ Legal ☐ Insurance

SPECIFIC TREATMENT PERIODS

Specific treatment date or time period for which the information is requested:

☐ Single treatment date of _____.
☐ Period of treatment from _____ to _____.
☐ Any and all treatment encounters to date.

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Specific description of information to be used or disclosed. (*Check only those that apply or select All Records.)*

Medical Records

☐ Progress Notes
☐ Doctor's Orders
☐ Billing Records
☐ Nurse's Notes
☐ Lab Reports
☐ Immunization Records
☐ Other Medical Records:

(Please Describe) _____

_____

_____

Mental Health Records

☐ Mental Health Records
☐ Psychotherapy Notes

*This is the only item you may request on this authorization. You must submit another authorization for other items requested.

All Records

☐ Health Treatment and Billing Records

I hereby consent to release my HIV test results: _____ (Initial) I have a right to refuse to release my HIV test results, except where release is authorized by law without my consent.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing.
4. If the receiver is not a health care provider, the information may no longer be protected by federal privacy regulations.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee.
6. I may have a copy of this form after I sign it.

SIGNATURES

I have read the above and authorize the disclosure of the Protected Health Information as stated.

Signature of Patient/Personal Representative:	Date:
Print Name of Patient's Personal Representative (*Authority document must be attached*):	Relationship to Patient

OFFICE USE ONLY

RECEIVED DATE: _____

TIME: _____

ATTEMPTED TO CONTACT PATIENT DATES: **LEFT MSG**:

1. _____ Y / N
2. _____ Y / N
3. _____ Y / N

☐ Faxed ☐ Mailed ☐ General Counsel
☐ No record found/Letter Sent INITIALS
SEND DATE: _____ _____