PATIENT INFORMATION FORM

Scheduler's Initials:_____ Scheduled With: Dr. Olga A. Katz

Date:_____ Appointment Date:_____ Patient Account #:_____

Last Name:_____ First Name:_____ MI_____ S.S. #:_____ Sex

Address:_____ City:_____ State:_____ Zip:_____ Age:____ DOB:_____

Phone #: ( )_____ Emergency Phone #: ( )_____ Marital Status:

Employer: _____

Address: _____

City:_____ State:_____ Zip:_____

Phone#: ( ) _____

Spouse/Parent/Guardian:_____

Employer: _____

Address: _____

City:_____ State:_____ Zip: _____

Phone#: ( ) _____

Referring Party: ☐ Doctor ☐ Employer ☐ Attorney ☐ Other

Referring Physician: _____

Address: _____

City:_____ State:_____ Zip: _____

Phone#: ( ) _____

Family Physician

(if other than above): _____

Address: _____

City:_____ State:_____ Zip: _____

Phone#: ( ) _____

Attorney:_____

Address: _____

City:_____ State:_____ Zip: _____

Phone#: ( ) _____

Pharmacy Information:

Party responsible for bill:

☐ Self ☐ Other - Explain: _____

Primary Medical Insurance

Insurance Co. Name: _____

Claims Office Address: _____

City:_____ State:_____ Zip: _____

Phone#: ( ) _____

Subscriber: _____

Relationship to Insured: _____

ID #: _____ Group #:_____

Secondary Medical Insurance

Insurance Co. Name: _____

Claims Office Address: _____

City:_____ State:_____ Zip: _____

Phone#: ( ) _____

Subscriber: _____

Relationship to Insured: _____

ID #: _____ Group #:_____

☐ Is this Major Medical Insurance? ☐ Y ☐ N

Auto Accident/Worker's Compensation Claims

☐ Auto ☐ Worker's Compensation

Name of Insured: _____

Date of Accident/Injury: _____ State: _____

Insurance Co. Name: _____

Claims Office Address: _____

City:_____ State:_____ Zip: _____

Phone#: ( ) _____

Policy/Claim #: _____

Adjuster: _____

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare/Medigap benefits be made either to me or on my behalf to Dr. Olga A. Katz of ADVANCED NEUROLOGY ASSOCIATES, P.C. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents, or any other insurance carrier (_____), any information needed to determine these benefits payable for related services.

_____ _____

Signature Date

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dr. Olga A. Katz of ADVANCED NEUROLOGY ASSOCIATES, P.C. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Signature Date

Olga A. Katz, M.D., Ph.D.
Advanced Neurology Associates, P.C.
822 Pine St., Suite 1C, Philadelphia, PA 19107
Telephone: 215-574-3573 • Fax: 215-574-3645

Prescription Drug Use Agreement

Dear Patient,

Use of prescription medication in anyway contrary to Dr. Katz's recommended frequency or dosage can cause serious damage to your health, including but not limited to organ damage or death. If you intend to change the use of your prescribed medicine either by altering the amount taken or how the medicine is used, you must contact our office first.

By signing below you, the patient, signify understanding and compliance with the above statement. Abuse or negligence of prescription drug use or possession will result in discharge from this practice.

Signature: _____ Date: _____

PRESCRIPTION CHANGE TO INSURANCE FORMULARY PREFERRED BRAND POLICY

Many insurance companies have selected or are in the process of selecting "preferred" brands of medications. Some pharmacies, at the request of your medical insurance company, have asked us to switch your prescribed medications to their preferred brand(s), which may be similar but not exactly the same as the medication we prescribed. Although you may do well on the insurance-preferred brand, we have no way of knowing in advance whether the insurance-preferred brand will be equally effective and as well tolerated by you as your physician-recommended medication. Under these circumstances, we feel it is not right for us to switch brands based solely on the insurance/pharmacist's request without your specific consent. If you agree to follow the insurance/pharmacist recommendation, then please notify us directly and we will comply with your request. Under these circumstances, we feel the only ethical way to handle these requests is to have the patient decide if they want to switch or not. Please note that not switching medications to the insurance-preferred brand may require the patient to incur additional expenses for medications.

Signature: _____ Date: _____

Authorization for the Use or Disclosure of Protected Health Information

I hereby 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: to furnish information to my insurance carriers concerning my illness and treatment or any information needed to determine these benefits payable for related service; and I hereby assign to the physician all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.
2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information: Olga A. Katz, M.D., Ph.D., and Advanced Neurology Associates, P.C.
3. I authorize the following persons (or class of persons) to receive my protected health information: Olga A. Katz, M.D., Ph.D., and Advanced Neurology Associates, P.C.
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 the right to revoke this authorization at any time. My revocation must be in writing *in a letter.* 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. Send revocation to Advanced Neurology Associates, P.C., 822 Pine St. Ste. 1C, Philadelphia, PA 19107.
6. My protected health information will be used or disclosed upon request for any services furnished to me by Olga A. Katz, M.D., Ph.D., and Advanced Neurology Associates, P.C.
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. paragraph 164.524).
8. I understand that Olga A. Katz, M.D., Ph.D., and Advanced Neurology Associates, P.C. will receive compensation for its use and/or disclosure of my protected health information.
9. I understand that protected health information may include history and physical exam, laboratory and testing reports, consultation reports and notes, prescription information, substance abuse information, human immunodeficiency virus-related information, mental health information and in accordance with Federal guidelines, urine analysis to establish compliance with prescribed medications.
10. I authorize collection, analysis and interpretation of all health-related samples and recordings, including tissue samples, biopsy samples, blood, urine and all other fluid samples, recordings of electric and functional activity, such as cardiography, encephalography, myography, nerve conduction studies, nystagmography and all associated clinical studies performed by Dr. Olga A Katz and all other staff.

I certify that I have received a copy of the authorization.

Signature:_____ Date:_____
Print Name:_____
Name of Authorized /Personal Representative:_____
Relationship to Patient:_____

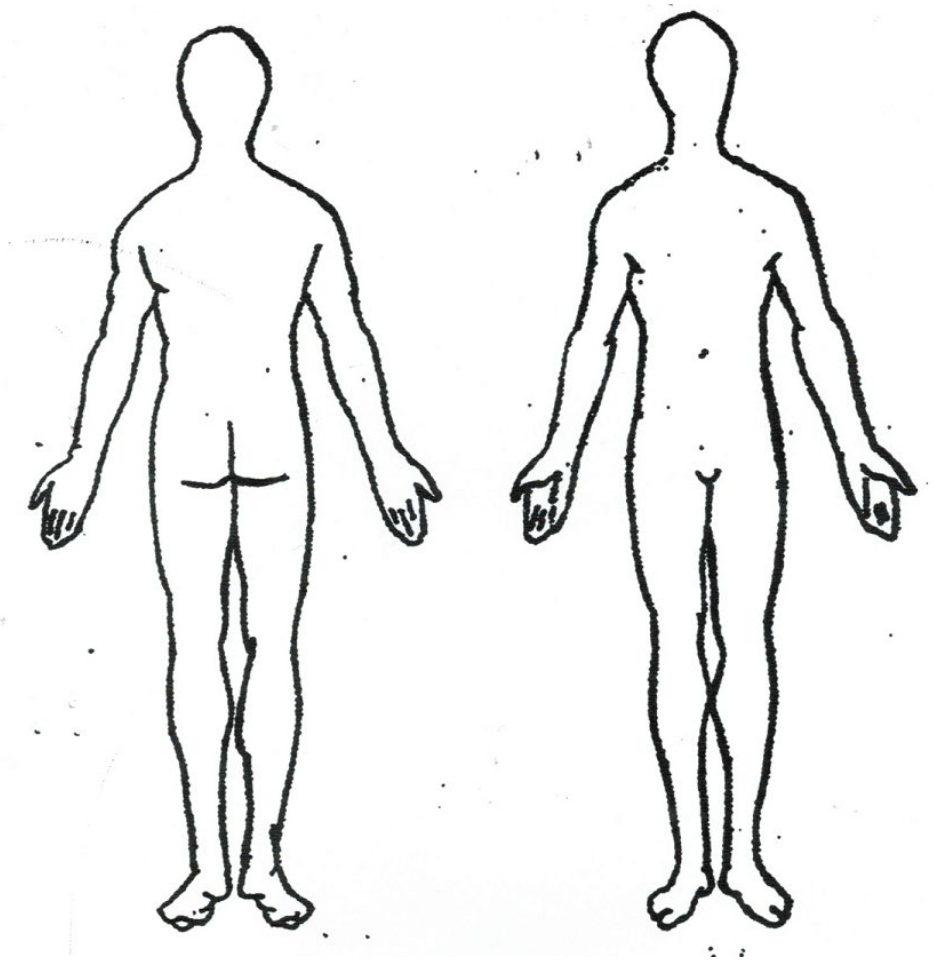
Pain Drawing

Your Name:_____

Date:_____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
□□□	= = =	O O O	x x x	/ / /	• • • • •



Left ***BACK*** ***Right*** ***FRONT*** ***Left***

Rate the intensity of your pain overall: ☐ 0. No pain ☐ 1. Mild ☐ 2. Discomfort ☐ 3. Distressing ☐ 4. Horrible ☐ 5. Excruciating

Please place an "X" along the line to describe your present pain situation.

NO PAIN |———|———|———| WORST POSSIBLE PAIN

PATIENT HISTORY

Name: _____ **DOS:** _____
Height: _____ **Weight:**_____ **Blood Pressure:**_____ **DOB:**_____ **Marital Status:**_____ **# of Children**_____

Are You □ LEFT HANDED □ RIGHT HANDED □ AMBIDEXTROUS
Occupation:_____**Physical Requirements of your Job** _____
Briefly describe your present condition_____
_____
Check this box if you have NOT had any previous accidents: □. Please list any/all surgeries you have undergone (include dates if possible):
_____
Have you ever had an MRI_____ **CT** _____ **EEG**_____ **EMG**_____ **List dates for all that apply:**_____
Are you presently have or you ever received psychological or/and psychiatric care □Yes □No
Are you presently receiving physical therapy? □ No □ Yes
Please check any of the following that apply and indicate when (year):

□ Skin Disorders _____ **□ Cancer** _____ **□ Jaundice** _____ **□ Eye infections** ____ **□ Colitis** ____

□ Problems with sleeping ____ **□Ear infections** _____ **□ Paralysis** ____ **□ Hearing Loss** ____ **□ Anemia** ____

□ Low Blood Pressure ____ **□ Heart Disease**____ **□ Rectal Disease** ____ **□ Sinusitis**____ **□ Fainting Spells**____

□ Kidney Disease____ **□ Hay Fever**_____ **□ Low Blood Sugar**____ **□ Bladder Infections**____ **□ Shortness of Breath** ____

□ Dental Problems____ **□ Diabetes** _____ **□ STD** ____ **□ Seizures**_____ **□ Broken Bones**____

□ Loss of Appetite ____ **□ Prostate Disease** ____ **□ Tuberculosis (TB)** ____ **□ Frequent Heartburn** _____ **□ Double Vision** ____

□ Impotence____ **□ Asthma** ____ **□ Gallbladder Disease** _____ **□ Menstrual Problems** ____ **□ Dizziness** ____

□ Pneumonia ____ **□ Stomach Ulcers**____ **□ Vaginal Infections** ____ **□ Meningitis** ____

□ Head Injury ____ **□ Joint Pain, Stiffness**____ **□ Bleeding Tendency**____ **□ Convulsions**____

□ Muscle Aches, Cramps ____ **□ Menopause** ____ **□ Severe Headaches** ____ **□ Back Pain** _____

□ Thyroid Disease ____ **□ Leg/Ankle Swelling**_____ **□ High Blood Pressure** ____ **□ Loss of Consciousness** ____

□ Loss of Vision ____ **□ Varicose Veins**____ **□ Chronic Cough** _____ **□ Racing heart** _____

Do you have any relatives with neurological disease? □ Yes □ No If Yes, please state relationship _____
Has anyone in your family other then yourself ever suffered from the following? Please list all members that apply:
□ Trouble getting to or staying asleep □Sleepiness during the day □Restless or jerking legs at night _____
□ Trouble breathing at night □ Allergies □ Asthma □ Anemia _____
□ Sudden attacks of weakness when exited □ Epilepsy, seizures, fits _____
□ Emotional or psychiatric problems □ Severe headaches _____

□ Suicides or suicide attempts □ Diabetes □ Obesity □ Thyroid gland disease _____
□ Stroke □ Brain Tumor □ Cancer □ Heart Problems _____
□ High Blood Pressure □ Low Blood Pressure _____

Name: _____ DOS _____

Social History:

1. Living in: ☐ home ☐ apartment ☐ other: _____
2. Living in household: ☐ ___# of people ☐ ___# of children ☐ ___# of children <18
3. Education: ☐ some high school ☐ HS graduate or GED ☐ some college ☐ college degree ☐ post graduate school ☐ grade:____ ☐ other: _____
4. Employment Status: ☐ part-time ☐ full-time ☐ retired ☐ disability
5. If disabled, why? _____ Other: _____
6. Type of work: _____ Occupation: _____

Risk Factors:

1. I drink or drank:_____ per ☐ day ☐ week ☐ month of alcoholic beverages
    a. Year began: _____ Year stopped: _____
2. Drug use: ☐ marijuana ☐ cocaine/crack ☐ heroin ☐ other: _____
    a. Year began: _____ Year stopped: _____
3. Past or current smoking history: ☐ Yes ☐ No
    a. I smoked ___ cigarette per ☐ day ☐ week ☐ month Year (_____) you stopped smoking
    b. I smoked ___ cigars per ☐ day ☐ week ☐ month
4. I drink ___ caffeinated beverages per ☐ day ☐ week
5. I use seatbelts regularly: ☐ Yes ☐ No

Lifestyle Factors:

1. Do you exercise? ☐ No ☐ Yes _____ X a week.
2. What type of exercise? _____
3. Are you on a special diet? ☐ No ☐ Yes
4. Any recent weight loss/gain? ☐ No ☐ Yes
5. Describe diet or weight change: _____

Family History:

Do you know of any blood relative who has had:
☐ heart disease ☐ hypertension ☐ stroke ☐ headache (migraine, cluster)
☐ neurologic disease (seizures, Alzheimer's) ☐ arthritis ☐ asthma ☐ cancer
☐ diabetes ☐ liver disease ☐ thyroid disease ☐ alcohol/psych disease (depression)
Please explain_____

If alive, give age & current health status (good/fair/poor).If deceased, give age & cause of death.
Father_____ Spouse _____
Mother _____ Children _____
Siblings _____

Allergies:

☐ foods ☐ medicines ☐ dye/iodine ☐ other
Please list allergies:_____
If allergic, what reaction did you have?
☐ skin ☐ stomach ☐ breathing ☐ other:_____

Name: _____

Medication List					
CURRENT Mediccation: Please list medication and daily dosage.					
Please list ALL medications currently taken; include over-the-counter medications and vitamins					
Medication	Daily Dosage	Side Effects Results	Medication	Daily Dosage	Side Effects Results
1			8		
2			9		
3			10		
4			11		
5			12		
6			13		
7			14		
PREVIOUS Medication for all neurological disorders.					
Medication	Daily Dosage	Side Effects Results	Medication	Daily Dosage	Side Effects Results
1			8		
2			9		
3			10		
4			11		
5			12		
6			13		
7			14		

Surgical History:

TYPE	YEAR	LOCATION

Allergies:

I realize that it is my responsibility to inform my medical provider of any and all medications that I am taking. By signing this form I certify that I have listed all medications I am currently taking as of today.

_____

Patient's Signature (Today's Date)

Name_____
Date_____

Headaches started _____ yrs ago or at age_____.
Frequency _____ Daily_____
Average Severity (pain scale of 1-10)_____
Duration?_____
Worsening Factors_____
Worse with menses? _____
Location: _____ R _____L_____B

LOCATION:

Temples_____ Back of Head_____ Side of Head_____ Front of Head_____ Around Head___

Eye_____ Ear_____ Neck_____ Jaw_____ Other_____

CHARACTER:

Throbbing/ Pulsing____ Achy_____ Tight_____ Dull_____ Pressure_____ Burning_____

Searing_____ Shooting_____ Stabbing_____ Other_____

ASSOCIATED SYMPTOMS:

Nausea_____ Vomiting_____ Diarrhea_____ Sensitive to: Light ___ Sounds____ Odors____

Constipation_____ Insomnia_____ Increased urination_____ Sore/Stiff neck_____

Ringing in the ears_____ Blurred Vision_____ Anxiety_____ Irritability_____ Concentration problems_____ Memory problems____ Confusion ____ Increased appetite_____ Decreased appetite_____ Eye-tearing (Rt Lt Both)____ Nose congested (Rt Lt Both) _____ Eye-redness (Rt Lt Both) _____ Drooping eyelid (Rt Lt Both) Change in pupil (Larger Smaller) Other (describe):_____

VISUAL AURAS:

Blurry vision_____ Loss of vison in one eye____ Tunnel vision____ Flashing lights_____ Loss of vison on one side_____ Double vision_____ Zigzag lines____ Total blindness_____ Floaters____
Other (please describe):_____

SENSORY AURAS:

Numbness/tingling-Right_____ Numbness/tingling- Left____ Numbness/tingling- Both_____
Dizziness/unsteadiness_____ Vertigo____ Light headiness_____ One-sided weakness_____
General weakness_____ Speech difficulty_____ Unable to speak_____ Other:_____
Does the sensory aura spread?_____ Yes-spread slowly_____ No- begins all at once_____

Provoking factors that bring on a headache:
Food/Beverage: Fasting____ Chocolate____ Caffeine____ Nitrates____ MSG_____
Alcohol beverages: Wine: Red_____ White____ Other:_____
Physical exertion: Coughing ____ Talking_____ Chewing_____ Exercise_____ Sexual intercourse_____
Hormonal: Menses: Before_____ During_____ After_____
Pregnancy_____ Menopause_____
Stress: Work_____ Home____ Family_____ Spouse_____ Other_____
Environmental: Allergies_____ Weather changes____ Altitude_____ Sunlight_____ Other_____
Sleep: Lack of sleep_____ Too much sleep _____ Change in wake/sleep_____
Other Triggers:_____

Relieving Factors (List):
Lying down____ Dark quiet room_____ Massage_____ Hot compress_____ Cold compress_____
Pregnancy_____ Keeping active/Pacing___ Standing_____
Other_____
Sleep Isuues?_____ falling asleep_____
Sexual Issues? _____
Previous Test?_____

Prior Medications:

Current Allergies:

Past Medical History:

Family History:

Olga A. Katz, M.D., Ph.D.
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Member, American Academy of Neurology