

NEUROLOGY ASSOCIATES OF LEE COUNTY
EDWARD F. STEINMETZ, M.D. • HARRIS L. BONNETTE, M.D.

12600 CREEKSIDE LANE, SUITE 7-FORT MYERS, FLORIDA 33919 Phone: (239) 939-2412 Fax: (239)-275-6566

PATIENT INFORMATION

Date _____

Patient's Legal Name _____

Last First Middle

Home phone # _____ Alternate # _____ Sex: M F Birth date _____ Age _____

SS# _____ Martial status S M W D Are you a Student? Y N

Home Address _____

Street

City St Zip

Accident: Work _____ Auto _____ Date of Accident _____ State _____

Patient's Occupation _____ Employer _____

Employer address _____

Driver License # _____ State _____

INSURANCE

Is Medicare your primary Insurance? Yes _____ No _____

Do you have a supplement insurance policy Yes _____ No _____

1st Insurance Carrier

Address _____

Policy # _____ Group # _____ Plane # _____

Subscriber's Name _____

Social Security # _____ Date of Birth _____

Patient's Relation to Insured Self _____ Spouse _____ Son _____ Daughter _____ Other _____

2nd Insurance Carrier

Address _____

Policy # _____ Group # _____ Plane # _____

Subscriber's Name _____

Social Security # _____ Date of Birth _____

Patient's Relation to Insured Self _____ Spouse _____ Son _____ Daughter _____ Other _____

AUTHORIZATION, PRIVACY & PAYMENT AGREEMENT

- When assignment is accepted, I hereby authorize payment directly to Neurology Associates of Lee County for Benefits (including Medicare benefits or major medical) payment under the terms of my insurance of governmental coverage for any services furnished me by Neurology Associates of Lee County. (Void after December 31 of this calendar year on Medicaid Claims.)
- Upon receipt of a request for release of medical information, I hereby authorize Neurology Associates of Lee County to release information acquired in the course of my examination or treatment.
- I hereby authorize any physician, hospital or medical care facility to provide information on my medical history and treatment to Neurology Associates of Lee County.
- I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and/or the State of Florida or their intermediary or fiscal agent any information needed for Medicare or Medicaid claims.
- I hereby certify that the information given by me in applying for payment under the Medicare or Medicaid programs is correct.
- I hereby authorize photocopies of this form to be as valid as the original.
- I hereby agree to be responsible for payment of the patient's account.

A complete Privacy Notice statement is available for your viewing upon request.

PLEASE NOTE OUR PAYMENT POLICY:

You are responsible directly to the office for payment of your account regardless of the status of medical or liability insurance claims. Office charges should be paid on the date incurred. All other charges are payable within 60 days. Accounts with charges 60 days or older will be subject to a rebilling fee. The undersigned hereby obligates him/herself to pay the account for medical services rendered. If this account is referred to an attorney or agency for collection, the undersigned shall pay for reasonable attorney's fees, collection expenses, court costs and recording fees.

DATE

SIGNATURE OF PATIENT AND/OR GUARANTOR

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MEDICAL INFORMATION

Patient's Legal Name _____ Date _____

CHIEF COMPLAINT _____

REFERRING PHYSICIAN _____

MEDICAL HISTORY

ALLERGIES _____

FAMILY HISTORY

Mother _____ Age _____
 Father _____ Age _____
 If deceased, give cause of death _____

 Number of Brothers _____ Sisters _____ Children _____

ILLNESSES: Do you have or have you had any of the following?

- | | | | | | |
|-------------------|--------------------------|---------------------|--------------------------|-------------------|--------------------------|
| AIDS | <input type="checkbox"/> | Goiter | <input type="checkbox"/> | Nervous Breakdown | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | Nose | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | Polio | <input type="checkbox"/> |
| Bleeding Tendency | <input type="checkbox"/> | Heart | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> |
| Blood Pressure | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | Skin | <input type="checkbox"/> |
| Bone | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | Stomach Ulcers | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Infections | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Colitis's | <input type="checkbox"/> | Injuries | <input type="checkbox"/> | Suicide Attempt | <input type="checkbox"/> |
| Congenital Heart | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | Throat | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Ear | <input type="checkbox"/> | Lung | <input type="checkbox"/> | Tumors | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | Migraine Headaches | <input type="checkbox"/> | V.D. | <input type="checkbox"/> |
| Eye Disease | <input type="checkbox"/> | Muscle Disease | <input type="checkbox"/> | | |

HOSPITALIZATIONS _____ SURGERY _____

SOCIAL HISTORY

YES NO DO YOU REGULARLY SMOKE? Cigarettes Pipe Cigars Number of years _____
 YES NO DO YOU DRINK OVER 6 CUPS OF COFFEE PER DAY?
 YES NO DO YOU REGULARLY DRINK ALCOHOL? 1 oz per day 2 oz per day 4 oz. per day over 6 oz. per day
 BEER: 1 bottle per day 2 bottles per day over 4 bottles per day
 WINE: 1 glass 1 bottle more
 YES NO DO YOU HAVE DIFFICULTY IN FALLING ASLEEP?
 YES NO DO YOU AWAKEN EARLY IN THE MORNING WITHOUT APPARENT CAUSE?
 YES NO ARE YOU TIRED MOST OF THE TIME?

CURRENT MEDICATIONS _____

NAME OF PERSON WHO COMPLETED THIS FORM? _____