NEUROLOGY CONSULTANTS OF NORTH JERSEY

Neurology Consultants of North Jersey, PA

Dr. Ayman Ibrahim, DO
Neurologist

Natalie Fattal, MSN, NP-C
Nurse Practitioner

194 Broad Street, Ste #4
Bloomfield, NJ 07003
t. 973.680.8400
f. 973.680.8404

92 Summit Avenue, 2nd Floor
Hackensack, NJ 07601
t. 201.630.0012
f. 201.630.0014

e. info@myneurocare.com
w. www.myneurocare.com

Appointment Date: _____

PLEASE PRINT CLEARLY: *Thank you*

PATIENT INFORMATION:

Name: _____ Sex: **M** **F** Date of Birth: _____

Address: _____ City: _____ State:_____ Zip:_____

Drivers License: _____ Soc. Sec # _____-_____-_____

Marital Status: S M W D Height: _____ Weight: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Language: _____ E-mail: _____

Employer: _____ Phone #: _____ Address: _____

Referring Physician: _____

Address: _____ Phone #: _____

Family Physician: _____

Address: _____ Phone #: _____

Primary Pharmacy: _____ Pharmacy Phone#: _____

Pharmacy Address: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Phone#: _____ Relationship: _____

****

INSURANCE INFORMATION:

Insurance Company: _____ Secondary Insurance: _____

Name of Insured: _____ DOB: _____ Name of Insured: _____ DOB: _____

Social Security: _____-____-_____ Social Security: _____-____-_____

Relationship: Self Spouse Child Other Relationship: Self Spouse Child Other

****

Is the reason for this due to an automobile accident? **YES** **NO**

Is the reason for this due to an accident at work? **YES** **NO**

Bill to: _____ **Address:** _____

Date of Accident: _____ **Claim#:** _____

Adjuster's Name: _____ **Phone#:** _____

PLEASE READ AND SIGN CONTINUING PAGES

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REQUEST FOR THE RELEASE OF PATIENT MEDICAL RECORDS

Patient's Name:_____

DOB: _____

INFORMATION TO BE DISCLOSED:_____

***SENDER: Name of Doctor/Facility authorized to release the above information:**

_____

Address:_____

Fax:_____

***RECIPIENT: Name of office to whom office may disclose the above information:**

Neurology Consultants of North Jersey, P.A.
194 Broad St. Suite #4, Bloomfield NJ 07003
Fax: 973-680-8404

_____

I authorize my health information to be sent to or by Dr. Ibrahim and it may be used for the purpose of future assessment and treatment.

I understand that my record may contain information about my mental health, personal information, disease information and/or information regarding drug and/or alcohol testing or treatment and that by signing this request, I am authorizing the release of any information in my record.

I authorize Dr. Ibrahim to use and disclose my health information in the manner described above.

_____

PATIENTS SIGNATURE **DATE**

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Family Medical History:

	Age	Diseases
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
	_____	_____
	_____	_____
Spouse	_____	_____
Children	_____	_____

Family History: (Circle all that apply)

Mental Retardation	Stroke
Muscular Dystrophy	Epilepsy
Multiple Sclerosis	Seizures
Heart Attack under 60	Alzheimer's
Brain Tumor	Cerebral Palsy

Review of Systems: Please indicate any personal history below:

Neurological Symptoms: (Please Circle all that apply):

Stroke, Ministroke, TIA	Frequent Headache	Epilepsy	Seizures
Work or Motor Vehicle Injures	Fainting Spells	Tremors	Light Headedness
Serious Head Injury	Pinched Nerve	Memory Problems	Psychiatric Hospitalization
Aspirin Allergy or Side Effects	Double Vision	Convulsions	Allergy to X-Ray Dye
Sciatica	Numbness in hands or feet	Paralysis	

Constitutional Symptoms:
Recent Weight Change..... No Yes
Recent Fever ..... No Yes
Fatigue..... No Yes

Eyes:
Eye Disease or injury..... No Yes
Blurred or double vision..... No Yes

Ears/Nose/Mouth/Throat:
Hearing loss or ringing..... .No Yes
Chronic sinus problem..... .No Yes
Swollen glands in neck..... No Yes

Cardiovascular:
Heart Attack..... No Yes
Chest pain or angina pectoris No Yes
Palpitation ..... No Yes
Shortness of breath w/walking
or lying flat .....No Yes
Swelling of feet, ankles
or hands .....No Yes

Respiratory:
Chronic or Frequent coughs ...No Yes
Spitting up blood ..... No Yes
Shortness of breath ..... No Yes

Gastrointestinal:
Loss of appetite ..... No Yes
Nausea or vomiting ..... No Yes
Frequent diarrhea ..... No Yes
Rectal bleeding or blood
in stool ..... No Yes
Abdominal Pain ..... No Yes

Genitourinary:
Frequent Urination .....No Yes
Kidney Stones .....No Yes
Sexual Difficulty ..... No Yes
Incontinence/dribbling No Yes
Female - # of pregnancies _____
Female - # of Miscarriages _____

Musculoskeletal:
Joint Pain ..... No Yes
Weakness of muscles
or joints ..... No Yes
Muscle pain/cramps... No Yes
Back pain ..... No Yes
Difficulty walking .... No Yes

Psychiatric:
Nervousness .....No Yes
Depression ..... No Yes
Insomnia ..... No Yes
Psychotherapy ..... No Yes

Hematological / Lymphatic:
Bleeding/bruising ..... No Yes
Anemia ..... No Yes
Phlebitis ..... No Yes
Enlarged glands ..... No Yes

Allergic / Immunologic:
History of rash or other allergic
reaction to medication ... No Yes

If Yes, Please List: _____
_____
_____
_____
_____

_____
_____

_____ _____

Dr. Ayman Ibrahim, DO **Date**

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Welcome to Neurology Consultants of North Jersey, P.A. Please fill out your medical history. Thanks

Patient Name: _____ Birthdate: _____Date: _____

Chief Complaint: _____

History of Present Illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(What does it seem like?)

Severity: _____
(How severe is the pain/problem on a scale of 1-5, 5 being the most severe?)

Duration: _____
(How long have you had this pain/problem?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms: _____
_____
(What other associated problems have you been having?)

Modifying Factors: _____
_____
(What makes the pain/problem worse or better? or have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "**No**" or "**Yes**", leave blank if uncertain)

Pneumonia ..... No Yes	Migraine Headaches . No Yes	High Blood Pressure. No Yes	Thyroid Condition. No Yes
Rheumatic Fever.. No Yes	Tuberculosis ..... No Yes	Asthma ..... No Yes	Bleeding Tendency No Yes
Heart Disease..... .No Yes	Diabetes ..... No Yes	AIDS or HIV ..... No Yes	Any other disease .. No Yes
Arthritis..... No Yes	Cancer ..... No Yes	Mitral valve Prolapse No Yes	(please list):
Venereal Disease. No Yes	Glaucoma ..... No Yes	Hepatitis ..... No Yes	_____
Anermia ..... No Yes	Blood Transfusion .. No Yes	Ulcer ..... No Yes	_____
Bladder Infections No Yes	Back Pain ..... No Yes	Kidney Disease ..... No Yes	_____

Previous Hospitalizations/Surgeries/Serious Illnesses:	**When?**	**Hospital, City, State**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription)_____
_____
_____

Are you taking any of these on a regular basis: (circle)

Aspirin Aspirin type medication Herbal Medication Vitamins Chiropractic Treatments

Circle any testing you previously had done:

EEG/Video EEG X-Ray CAT Scan EMG/NCV VNG (balance test) MRI Scan TCD

Patient Social History:

# of Children _____	Single _____	Married _____	Separated _____	Divorced _____	Widowed _____
Use of Alcohol:	Never _____	Rarely _____	Moderate _____	Daily _____	
Use of Tobacco:	Never _____	Previously, but quit after _____years		Current packs/day _____	
Use of Drugs:	Never _____	Type/Frequency: _____			

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PATIENT ACKNOWLEDGEMENT

By signing this form, you help us by confirming that you have received our **Notice of Privacy Practice.** We are required by law to ask for your signature on this form.

The Notice of Privacy Practice contains information about how we may use and disclose health information about you. Please review the **Notice of Privacy Practices**. You may ask questions about our practices.

In accordance with the law or government regulation, or for patient care reasons, privacy practice may change. If we change our Notice of Privacy Practices, we will give you a new copy when you come in. If you write to ask for a copy of Notice of Privacy Practices, we will send it to you.

You have the right to request that we restrict how health information about you is used for treatment, payments or other health care procedures. However, the law recognizes that there may be reasonable disagreement and so we are not required to agree with your request for restrictions on how the information is used.

***** I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS*****

PATIENT NAME: _____

SIGNATURE: _____

DATE: _____

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DATE: _____

PATIENT: _____

INSURANCE ID#: _____

GROUP #: _____

I , _____. Understand that services rendered to me by **Dr. Ayman Ibrahim** is my financial responsibility and the provider will bill my insurance company, _____ as a courtesy. I authorize my insurance company to pay my benefits directly for **NEUROLOGY CONSULTANTS OF NORTH JERSEY, P.A** and I understand that I will be fully responsible for any deductibles or co-insurance that was applied for services was rendering. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee and **I have agreed to pay,** in a current manner, any balance of said professional services charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim.

I authorize the provider to realize any information necessary to adjudicate the claim, and understand that there may be associates cost for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payments to me, **I will forward** the payment to **NEUROLOGY CONSULTANTS OF NORTH JERSEY, P.A** within 48 hours. **I agree** that if I fail to send the payment to the provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receive any check, draft or payment subject to this agreement. I will immediately deliver said check, draft or payment to the provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason in my behalf and I personally will be active in resolution of claims delay or unjustified reductions or denials.

PATIENT NAME: _____

SIGNATURE: _____

WITNESS: _____