Chattanooga Neurology Associates

Memorial Medical Building, Suite 467 - 721 Glenwood Drive - Chattanooga, TN 37404
Phone (423) 698-3423

DATE _____ REFERRED BY DR. _____

PATIENT NAME _____ SS# _____
(LAST, FIRST, MI)

ADDRESS _____

CITY AND STATE _____ ZIP _____ PHONE _____

AGE _____ DATE OF BIRTH _____ MARITAL STATUS _____ SEX _____
(M/F)

EMPLOYER _____ EMP PHONE _____

EMPLOYER'S ADDRESS _____ CITY_____ ST___ ZIP _____

SPOUSE, PARENT, NEXT OF KIN _____ PHONE _____

DATE OF BIRTH _____ SS# _____

EMPLOYER _____ EMP PHONE _____

ADDRESS _____CITY_____ ST___ ZIP _____

NATURE OF ILLNESS OR INJURY _____

DATE OF FIRST SYMPTOM OR DATE OF INJURY_____

IS THIS WORKMAN'S COMPENSATION? _____VERIFIED _____

WORKMAN'S COMP CARRIER_____ PHONE _____

CARRIER ADDRESS _____CITY_____ ST____ ZIP _____

ADJUSTOR'S NAME _____ CLAIM# _____

EMPLOYER AT TIME OF ACCIDENT/SYMPTOMS_____

NAME OF INSURED _____ COVERED THRU (EMP) _____

DATE OF BIRTH _____ S.S. # _____

HEALTH INSURANCE - PRIMARY CARRIER _____

CARRIER ADDRESS _____CITY_____ ST___ ZIP _____

GROUP #_____ CONTRACT OR ID#_____

HEALTH INSURANCE - SECONDARY CARRIER _____

CARRIER ADDRESS_____CITY_____ ST___ ZIP _____

GROUP #_____ CONTRACT OR ID# _____

NAME OF INSURED_____COVERED THRU (EMP)_____

I HEREBY AUTHORIZE _____ M.D. TO RELEASE ANY INFORMATION TO THE INSURANCE COMPANIES COVERING MY PROCEDURES FOR ANY SERVICES RENDERED. I ALSO AUTHORIZE DIRECT PAYMENT TO _____ M.D. BY THE INSURANCE COMPANY OF ANY BENEFITS DUE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THE ASSIGNMENT.

DATE _____ SIGNED _____

Chattanooga Neurology Associates, PLLC, IPA

721 Glenwood Drive, Suite 467 West, Chattanooga, TN 37404

Patient Name:_____

May we leave messages including test results on your answering machine? Yes ____ No ____

May we call you on your cell phone: Yes ____ No ____

Cell Phone # _____

May we give test results to your family members? Yes ____ No ____

If yes, please list their names below:

Name	Phone	Cell Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact: _____

Phone _____ Cell _____

May we call you at work, if necessary? Yes ____ No ____

If yes and unavailable, may we leave a message? Yes ____ No ____

Work Phone: _____

Do you have a durable power of attorney for healthcare? Yes ____ No ____

If yes, please provide the following:

Name: _____

Relationship: _____

Address: _____

_____

Phone: _____

Signature: _____ **Date:** _____

PATIENT MEDICAL HISTORY

EMG LAB

DO YOU CURRENTLY HAVE, OR DO YOU HAVE A HISTORY OF THE FOLLOWING MEDICAL CONDITIONS?

	YES	NO
HEART DISEASE	____	____
CANCER	____	____
DIABETES	____	____
HEPATITIS	____	____
HIV POSITIVE	____	____
AIDS	____	____
TUBERCULOSIS (TB)	____	____

_____

PATIENT SIGNATURE

HAVE YOU EVER HAD EMG OR NERVE CONDUCTION STUDIES PERFORMED?_____

IF YES, WHERE?_____