MIND Headache and Neurology PLLC
11929 University BLVD Ste. 1B
Sugar Land, TX 77479
P 281.402.9522 F 281.560.4550

PATIENT INFORMATION

Name: _____ Date of Birth:_____
First *MI* *Last*

Address:_____ City:_____State:_____ Zip:_____
Residence Type:❑Private Residence ❑Nursing Home (Not a SNF) ❑Skilled Nursing Facility or Hospice

Sex:❑Male ❑Female ❑Transgender Last 4 SSN #:_____

Marital Status:❑Single ❑Divorced ❑Married ❑Partnered ❑Widowed ❑Legally Separated ❑Other

Ethnicity:❑Caucasian ❑African-American ❑Asian/Pacific-Islander ❑Hispanic ❑Other

Employment Status:❑Full-Time ❑Part-Time ❑Not Employed ❑Full-Time Student
Employer (if applicable): _____ Occupation:_____

Home Phone:
(_____) _____ - _____
❑ This is my preferred number
May we leave personal/medical information on your voicemail?
❑Yes ❑No

Cell Phone:
(_____) _____ - _____
❑ This is my preferred number
May we leave personal/medical information on your voicemail?
❑Yes ❑No
**I understand a cellular phone is not a secure private line.*

Work Phone:
(_____) _____ - _____
❑ This is my preferred number

Email: _____

INSURANCE COVERAGE

It is very important that you bring your photo identification card and insurance card(s) on the day of your appointment. Please remember that it is your responsibility to obtain a referral from your primary care physician (if your insurance requires it).

Primary Insurance
Carrier:_____ ID#:_____ Group#: _____
Name of insured:_____
Insured's Date of birth:_____ Relationship to insured: ❑Self ❑Spouse ❑Other:

Secondary Insurance
❑ I do not have a secondary insurance Carrier:
Carrier:_____ ID#:_____ Group#: _____
Name of insured:_____
Insured's Date of birth:_____ Relationship to insured: ❑Self ❑Spouse ❑Other:

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EMERGENCY CONTACTS

Please check a box below indicating whether or not you would like to have the selected contact(s) added as an authorized HIPAA contact.

Primary Emergency Contact
❑ I authorize ❑ I do **NOT** authorize the disclosure of my protected health information (PHI) to the person listed as my Primary Emergency Contact.
Name:_____
Home/Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Relationship: ❑Spouse ❑Parent ❑Partner ❑Child ❑Sibling ❑Other: _____

Secondary Emergency Contact
❑ I authorize ❑ I do **NOT** authorize the disclosure of my protected health information (PHI) to the person listed as my Primary Emergency Contact.
Name:_____
Home/Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Relationship: ❑Spouse ❑Parent ❑Partner ❑Child ❑Sibling ❑Other: _____

PRIMARY CARE PROVIDER

Name:_____ Phone: (_____) _____ - _____

REFERRING PROVIDER

Name:_____ Phone: (_____) _____ - _____

HOW DID YOU HEAR ABOUT US?

❑Physician/Provider Referral ❑Family or Friend ❑Website or Search Engine ❑Other

REASON FOR VISIT TODAY

_____
_____
_____

PAST MEDICAL HISTORY(e.g. diabetes, high blood pressure, cancer, TB)

_____
_____
_____
_____

SURGERY AND HOSPITALIZATION HISTORY (Please list all surgeries, hospitalizations, and major illnesses with dates)

_____
_____

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PREVIOUS TESTING *Have you had any previous imaging or diagnostic tests including MRI, CT, EEG? Please list tests and where this was performed.*

FAMILY HISTORY *List any major illnesses in your family, including parents, grandparents, siblings, or children, (e.g. diabetes, hypertension, multiple sclerosis, etc...)*

ALLERGIES *List any allergies you have to medications*

PHARMACIES

Primary Pharmacy
Type:❑Local ❑Mail-Order ❑Specialty Name:
Address:_____ City:_____
Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Secondary Pharmacy
Type:❑Local ❑Mail-Order ❑Specialty Name:
Address:_____ City:_____
Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

CURRENT MEDICATION LOG *List all medications (prescribed or over the counter/herbal supplements) that you are currently taking:*

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INTAKE QUESTIONNAIRE

NAME: _____ DATE: _____

Within the past 6 months, have you experienced any of the following?

Weight change	❍Yes ❍No
Hearing loss	❍Yes ❍No
Heart palpitations	❍Yes ❍No
Difficulty swallowing	❍Yes ❍No
Seizure	❍Yes ❍No
Loss of vision	❍Yes ❍No
Shooting leg pain	❍Yes ❍No
Shooting arm pain	❍Yes ❍No
Fainting spells	❍Yes ❍No
Rash	❍Yes ❍No
Blood transfusion	❍Yes ❍No
Diabetes	❍Yes ❍No
Nasal/seasonal allergies	❍Yes ❍No
Difficulty urinating	❍Yes ❍No
Sleep problems	❍Yes ❍No
Memory problems	❍Yes ❍No
Episodes of confusion	❍Yes ❍No

Within the past 12 months, have you fallen?

❍Yes ❍No

Have you ever been exposed to HIV?

❍Yes ❍No ❍Unknown

Which hand do you write with?

❍Right ❍Left ❍Both

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ACKNOWLEDGEMENT FORM

By signing my name below, I:

- Consent to receive the following documents electronically which are available through our Patient Portal or through our website unless I request a non-electronic paper copy of the documents disclosed herein.
    - - MIND Headache and Neurology's Notice of Privacy Practices
    - - MIND Headache and Neurology's Financial Policy
    -
- Authorize:
    - - The release of any medical and/or other information necessary to process my claims.
    - - Payment of medical benefits to my treating physician or supplier for services rendered by MIND Headache and Neurology.
    -
- **Have read and agree to all of the above policies and understand that my failure to comply with any of these policies may result in discharge from MIND Headache and Neurology.**

Signature_____