PATIENT INFORMATION RECORD

NEW MEXICO NEUROLOGY ASSOCIATES, P.C.

Manuel A. Gurule, M.D.

Patient Name_____ M/F _____

Date of Birth_____ Age_____ Social Security # _____

Mailing Address:_____ City/State/**Zip** _____

Home Phone_____ Cell Phone _____

Employer_____ Work Phone _____

Name of Insured/Guarantor_____ DOB & SS#_____
(REQUIRED FOR TRICARE)

Emergency Contact/Spouse/Guardian_____ Phone Number_____

REFERRING PHYSICIAN_____ Phone Number_____

PRIMARY CARE PHYSICIAN_____ Phone Number _____
(As on your insurance card)

In order to comply with the new healthcare laws we must ask the following questions:

Please Circle

Patient Race:_____ Patient Ethnicity Hispanic or Latino Not Hispanic

Pharmacy Name:_____ Pharmacy Phone #:_____

Pharmacy Location: _____

****A COPY OF YOUR INSURANCE CARD IS NECESSARY TO ENSURE PROPER FILING****

It is the patient's responsibility to provide our office with the correct insurance information at the time of service. Incorrect insurance information will result in denial of claim payment for which the patient will be completely responsible.

I,_____, herby authorize any physician, medical practioner, hospital, or medical related facility, insurance company, or other institution or persons having any records, charts, x-rays, CTs, MRIs, laboratory work, or similar information or knowledge of me or my health, including, but not limited to, information related to AIDS/HIV/ARCH, to release such information to *NEW MEXICO NEUROLOGY ASSOCIATES, P.C.,* or its authorized representative(s) performing services in connection with my medical care or as lawfully required.

I also authorize *NEW MEXICO NEUROLOGY ASSOCIATES, P.C.* to release my medical information to *ANY* doctors and other health professionals involved in my medical care. I also authorize *NEW MEXICO NEUROLOGY ASSOCIATES, P.C.* to release my medical information to *myself.*

I, the undersigned, authorize payment of insurance benefits directly to *NEW MEXICO NEUROLOGY ASSOCIATES, P.C.* I authorize *NEW MEXICO NEUROLOGY ASSOCIATES, P.C.* to release any information concerning my (or my dependent's) healthcare, advice, and treatment provided to my insurance company, my employer, and 3rd party payer administrator for the purpose of evaluating and processing my claims. As the responsible party, I agree that I am responsible for co-payments, co-insurance, and/or deductibles in accordance with the terms and conditions of my health insurance policy**. I agree that in the event my insurance company denies payment, or I have no insurance, that I am ultimately responsible for the unpaid balance of my account.**

I am aware that *NEW MEXICO NEUROLOGY, P.C.* charges a fee if I do not call and notify them of my cancellation within twenty-four (24) hours of my appointment.

I acknowledge that I have been given the opportunity to review and/or receive a copy of the **NOTICE OF PRIVACY PRACTICES** on record at *NEW MEXICO NEUROLOGY ASSOCIATES, P.C.*

Signature of Patient/Responsible Party_____ Date _____

PATIENT EMAIL: _____

*******If this visit is related to a motor vehicle accident, our office requires a Letter of Protection prior to your visit.**

*******If this visit is related to a workers compensation claim, our office requires appropriate billing information and approvals *prior* to your visit. Otherwise, you will be directly responsible for payment.**

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NEW MEXICO NEUROLOGY ASSOCIATES, P.C.

Manuel A. Gurule, M.D.

Patient Name_____Date of Birth_____Age_____

Height_____Weight_____**BMI_____%____Normal __Above __Below**

Care Plan Given:

__Exercise Counseling __Nutrition/Dietary Counseling __BMI Management Provided

BP_____Heart Rate_____ **__NORMAL __ABNORMAL**

Care Plan Given:

__Referral to Alternative / PCP __Physical Activity Recommended __Weight Reduction Recommended

Have you had the following Immunizations this year?

Influenza Immunization: Y N
If Yes please provide approx date:_____
Given by: PCP_____Other_____

Pneumococcal Immunization: Y N
If Yes please provide approx date:_____
Given by: PCP_____Other_____

Social History

Do you use any of the following?

Tobacco	Y	N	PACKS PER DAY FOR YEARS
Alcohol	Y	N	DRINKS PER DAY

Patient counseled on Tobacco use:_____Date:_____

Patient counseled on Alcohol use:_____Date:_____

Please list current Medications

NAME OF MEDICATION / DOSAGE	NAME OF MEDICATION / DOSAGE

Preventive Medicine for patients 65 YEARS OR OLDER

Have you had any falls since January of this year? Y N
If yes – How many falls have you had?_____Was there an injury with the fall? Y N

Assessment Performed
Assessment Not Performed, due to medical reason:
Assessment Not Performed, no reason specified:_____
Documented: Y N

_____ _____

Physicians Signature **Date**