DR. JEANETTE M STRAGA
COASTAL NEUROLOGICAL CONSULTANTS, A PROFESSIONAL CORPORATION
NEUROLOGY

DEMOGRAPHIC FORM

PATIENT INFORMATION

DATE: ________________

NAME ____

AGE: __________ DATE OF BIRTH: ______________________ SOCIAL SECURITY # ________-______-_________

MARITAL STATUS: (circle one) Single Married Separated Divorced Widowed

PERMANENT ADDRESS: ______________________________________ HOME PHONE: ____________________
______________________________________ CELL PHONE: ____________________

LOCAL OR
TEMPORARY ADDRESS: ______________________________________ OTHER PHONE: __________________
____

Months you reside at this address: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

PLEASE CIRCLE THE TWO BEST WAYS TO REACH YOU: HOME CELL WORK OTHER

EMPLOYED BY: ____ PHONE: ____________________

SPOUSE OR PARTNER’S NAME: ____

EMERGENCY CONTACT PERSON: ___________________________________ PHONE: ____________________

REFERRING PHYSICIAN: ____

PERSON RESPONSIBLE FOR THE ACCOUNT: ____

INSURANCE INFORMATION

NAME & ADDRESS OF PRIMARY INSURANCE
____
____
____

ID # ________________________________
GRP #_______________________________
SUBSCRIBER: _________________________

NAME & ADDRESS OF SECONDARY INSURANCE
____
____
____

ID # ________________________________
GRP #_______________________________
SUBSCRIBER: _________________________

IS THIS VISIT RELATED TO AN ACCIDENT? _____ YES _____ NO (Please check one of the following)

_____ AUTO ACCIDENT _____ WORK RELATED ACCIDENT ____ ANY OTHER TYPE OF INJURY

If “yes”, what was the date of the accident? ________________________

If Auto Accident, Do You Have an Attorney: __________ YES __________ NO

NAME: ____ PHONE: ______________

ADDRESS: ____ FAX: ______________

(***PLEASE SIGN AUTHORIZATION AND RELEASE ON THE NEXT PAGE***)

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AUTHORIZATION FOR MEDICAL CARE AND RELEASE OF INFORMATION

PATIENT'S NAME ____

I hereby request Dr. Jeanette M Straga and Coastal Neurological Consultants, a Professional Corporation to evaluate my medical problem and after consultation with me to provide me medical treatment.

Date: __________ Patient/Guardian Signature: ____

Dr. Jeanette M Straga and Coastal Neurological Consultants, a Professional Corporation does not accept assignment of insurance. We will assist you in filing your claim and we will provide you with the completed forms and a pre-stamped, addressed envelope ready for you to mail as you leave our office.

Date: __________ Patient/Guardian Signature: ____

Your signature on the line below indicates that you agree to pay in full for office visits before you leave the doctor's office. By signing below, you acknowledge financial responsibility for all charges regardless of insurance, unless regulated by law.

Date: __________ Patient/Guardian Signature: ____

DR. JEANETTE M STRAGA
COASTAL NEUROLOGICAL CONSULTANTS, A PROFESSIONAL CORPORATION
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PATIENT HEALTH QUESTIONNAIRE DATE: _______________

NAME: ____ **AGE**: __________

MARITAL STATUS: (Please circle your response) Married Single Divorced Separated Widowed

CHILDREN: (Please circle your response) YES NO How Many? ________ THEIR AGES: ____________________

WHAT IS YOUR OCCUPATION: ____

ARE YOU "RIGHT – HANDED" OR ARE YOU "LEFT – HANDED" (Please circle one of the two)

1. **WHY ARE YOU HERE TO SEE DR. STRAGA ?**

____

____

____

2. **PAST MEDICAL HISTORY**: (Please list any other medical problems or injuries you have now, or have had, in the past).

____

____

____

3. **PLEASE LIST ANY SURGERIES AND THE DATE YOU HAD THEM**

1. ________________________ 4. ________________________

2. ________________________ 5. ________________________

3. ________________________ 6. ________________________

3. MEDICATIONS: Please list all medications (including over-the-counter medications) that you are currently taking. Please include the dose and how often you take them.

MED # 1: ________________________ MED # 4: ________________________

MED # 2: ________________________ MED # 5: ________________________

MED # 3: ________________________ MED # 6: ________________________

5. **ARE YOU ALLERGIC TO ANY MEDICATIONS?** YES NO (Please circle your response)
IF YES, WHAT ARE YOU ALERGIC TO AND DESCRIBE YOUR REACTION:

____

____

6. **DO YOU SMOKE?** YES NO HOW MUCH? __________________ FOR HOW LONG? __________________

7. **HAVE YOU EVER SMOKED?** YES NO HOW MUCH? _______________ FOR HOW LONG? _____________
WHEN DID YOU QUIT? _________________________

8.. **BEVERAGES THAT CONTAIN CAFFEINE**:

a. Do you drink coffee? Yes No (Please circle your response) How much ____________________
b. Do you drink tea? Yes No (Please circle your response) How much ____________________
c. Do you drink sodas (Coke, Pepsi, etc.) Yes No (Please circle your response) How much ______________

NAME: (Yes, again) ____

9. **DO YOU DRINK ALCOHOL?** YES NO (Circle your response) HOW OFTEN? _________ HOW MUCH? _______

10. **FAMILY HISTORY:** PLEASE COMPLETE THIS SECTION FULLY

	Alive/Age	Deceased/Age	Cause of Death
MOTHER:	__________	____________	____

Please list Mother's medical problems:

____

____

	Alive/Age	Deceased/Age	Cause of Death
FATHER:	__________	____________	____

Please list Father's medical problems:

____

____

	Alive/Age	Deceased/Age	Cause of Death
SIBLINGS:	__________	____________	____
	__________	____________	____
	__________	____________	____
	__________	____________	____

Please list any sibling's medical problems. Please list your brother(s) or your sister(s)

____

____

____

____

11. **ARE THERE ANY DISEASES THAT RUN IN YOUR IMMEDIATE FAMILY?**

____

____

____

12. **IF YOU ARE HERE TODAY BECAUSE OF HEADACHES, ARE THERE ANY IMMEDIATE FAMILY MEMBERS THAT ALSO HAVE HEADACHES?**

____

____

13. **DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS ASSOCIATED WITH YOUR HEADACHES?**
(Circle all that apply)
Noise Sensitivity Nausea Visual Changes Vomiting Light Sensitivity

LIST ANY OTHER SYMPTOMS THAT YOU EXPERIENCE:

____

____

____

____

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REVIEW OF SYSTEMS

NAME:			DATE: ____/____/______		
REVIEW OF SYSTEMS		Please CIRCLE all of your SYMPTOMS, if it applies:			
GENERAL	Weight Loss	Weight Gain	Fatigue	Headache	Fever
EYES	Visual Loss	Double Vision	Eye Pain	Droopy Lids	Blurry Vision
Ears, Nose, Throat, ENT	Hearing Loss	Ringing in Ears	Loss of Smell	Can't Swallow	Dizzy
CARDIOVASCULAR	Chest Pain	High Blood Pressure	Palpitations	Leg Swelling	Fainting
RESPIRATORY	Cough	Bloody Sputum	Short of Breath	Phlegum	Night Sweats
GI	Nausea	Vomiting	Constipation	Diarrhea	Black Bowl Movement
GU	Painful Urination	Sexual Issues/Problems	Unable to Empty Bladder	Frequent Urination	Bloody Urine
MUSCULOSKAL	Joint Pain	Muscle Pain	Weakness	Back Pain	Neck Pain
SKIN/BREAST	Rash	Itching	Change of Color	Milk From Breast	Breast Lump
NEUROLOGICAL	Numb or Tingling	Falling or Imbalance	Memory Loss	Speech Problems	Tremors
ENDOCRINE	Heat Intolerance	Cold Intolerance	Excess Urination	Excess Thirst	Always Hungry
HEMO/LYMPH	Swollen Glands	Pallor	Bleeding	Bruising Easily	Anemia
ALLERGIC/IMMUNE/ SLEEP	Frequent Infections	Food Allergies	Insomnia	Sleeping too Much	Snoring/Apnea
PSYCHIATRIC	Confusion	Hallucinations	Feelings of Persecution	Depression	Anxiety/Nervous
PLEASE ELABORATE ANY POSITIVE SYMPTOMS CIRCLED ABOVE OR ANY OTHER SYMPTOMS					

____

____

____

____

DR. JEANETTE M STRAGA
COASTAL NEUROLOGICAL CONSULTANTS, A PROFESSIONAL CORPORATION
433 N CAMDEN DRIVE SUITE 780
BEVERLY HILLS, CA 90210

PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, prepayment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our Privacy Policy notice which is posted on our web site at www.CoastalNeurologicalConsultants.com.

____
Date

____
Print Patients Name Here

____
Patients Signature Here

RECORDS RELEASE REQUEST

DATE: ____________________

TO: ____

ADDRESS: ____

CITY: ______________________________ STATE: ____________________ZIP: __________

I hereby authorize the release of my Medical Records (including any Films and/or Scans) or any copies of such to:

DR. JEANETTE M STRAGA
COASTAL NEUROLOGICAL CONSULTANTS, A PROFESSIONAL CORPORATION
433 N CAMDEN DRIVE SUITE 780
BEVERLY HILLS, CA 90210

NEUROLOGY

Phone: (310) 285-9700
Fax: (310) 285-9609

Email: Info@CoastalNeurologicalConsultants.com

PRINT NAME OF PATIENT: ____

SS# ______________________________________ DATE OF BIRTH: ___________________

SIGNATURE:____
(Patient, Parent, or Guardian)