MUSCLE AND NERVE, PA

601-982-9826 FAX:601-982-9535

Michael C. Graeber, MD **Alan R. Moore, MD**

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Preferred Language

☐ English ☐ Spanish ☐ Other – Specify _____

Race/Ethnicity

☐ American Indian or Alaska Native
☐ Caucasian/White
☐ Multiracial
☐ Hispanic or Latino
☐ Black or African American
☐ Refused/Declined
☐ Asian
☐ Native Hawaiian or Other Pacific Islander

HEIGHT: _____ ***WEIGHT:*** _____

Smoking Status/Tobacco Use

☐ Not a current tobacco user ☐ 1-2 packs per day ☐ Few (1-3) cigarettes per day
☐ 2 or more packs per day ☐ Up to 1 pack per day ☐ Other _____

Alcohol Use : How much per day? _____ ***Caffeine Use: How much per day?*** _____

Review of Systems

Weakness	N / Y	Double Vision	N / Y	Edema (Swelling)	N/ Y
Numbness	N / Y	Slurred Speech	N / Y	Rash	N / Y
Tingling	N / Y	Difficulty Swallowing	N / Y	Headaches	N / Y
Stiffness	N / Y	Shortness of Breath	N / Y	Balance Complaints	N / Y
Cramps	N / Y	Constipation/Diarrhea	N / Y	Neck Pain	N / Y
Fatigue	N / Y	Urinary Difficulties	N / Y	Back Pain	N / Y
Wt Loss	N / Y	Impotence	N / Y	Anxiety/Depression	N / Y
Muscle Pain	N / Y	Fever	N / Y		

LIST ANY ALLERGIES AND REACTIONS: **OR INDICATE - ☐ NONE**

_____
_____
_____

Medication List

MEDICATION NAME DOSAGE HOW OFTEN

_____
_____
_____
_____
_____

SIGNATURE/REVIEWING PHYSICIAN _____

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NAME_____ SEX_____

MAILING
ADDRESS_____

CITY_____ STATE_____ ZIP_____

EMPLOYER_____ EMAIL ADDRESS _____

HOME PHONE_____ WORK PHONE_____

DATE OF BIRTH_____ SOCIAL SECURITY_____

REFERRING DOCTOR_____

INSURANCE COMPANY NAME_____

INSURED'S NAME_____

INSURED'S DATE OF BIRTH_____ INSURED'S SSN_____

INSURED'S EMPLOYER_____ INSURED'S WORK NUMBER _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MUSCLE AND NERVE, P.A.

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO OTHER TREATING PHYSICIANS.

I HEREBY AUTHORIZE RELEASE OF ANY AND ALL MEDICAL RECORDS CONCERNING PHYSICAL OR MENTAL HEALTH, DIAGNOSES OR TREATMENT TO:
DR. MICHAEL C. GRAEBER / DR. ALAN R. MOORE

I HEREBY ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES IN THE EVENT THAT INSURANCE OR WORKMAN'S COMPENSATION FAILS TO PAY, AND AGREE TO PAY THE PORTION MY INSURANCE IS NOT RESPONSIBLE FOR.

SIGNATURE_____ DATE_____

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information described below for the purpose of neurodiagnostic testing and evaluation. I understand that this authorization is voluntary. I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV, or genetic information. I understand that I may revoke this authorization at any time by notifying Muscle and Nerve, PA in writing: but, if I do it will not have an effect on any actions taken before the receipt of the revocation. The revocation will include the patient name, date of birth, address and social security number. I understand that his authorization will expire six (6) months from date the authorization is signed.

Consent to the use and disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, test results and diagnoses. I understand that this information serves as:

- a means of communication among other health care professionals who contribute to my care
- a source of information of applying my diagnosis information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that I was provided with and have read the Notice of Privacy Practices describing the uses and disclosures of PHI (personal health information) by Muscle and Nerve, PA.

PATIENT NAME (PRINT) _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

Signature of patient (OR) Legal Representative _____ Date _____

Witness _____ Date _____

PREVIOUS DIAGNOSTIC TESTING

Check	Diagnostic Test	Date Performed	Referring Physician	Name of Facility Where Performed
_____	MRI	_____	_____	_____
_____	CT	_____	_____	_____
_____	Myelogram	_____	_____	_____
_____	EMG/NCS	_____	_____	_____
_____	X-RAYS	_____	_____	_____
_____	OTHER	_____	_____	_____