Dear Patient,

Welcome to Rocky Mountain Movement Disorders Center, P.C. and thank you for scheduling your appointment with us. Our mission and goal is to provide the highest quality, most state of the art care, for all patients and families affected by movement disorders. The road to improving your quality of life begins here.

Please fill out the forms provided in this packet and bring them with you to your first appointment. Along with these forms, please plan to bring the following items with you to your appointment:

- Insurance card(s) – Including your Medicare and Medicaid cards if you have them.
- Driver's License or state photo ID card.
- Payment for your visit co-pay, if applicable.
- All original medication bottles for medications currently prescribed.
- If available, Power of Attorney (POA) and/or Advanced Directive forms.

If you have not already sent the following items or provided the information to our office, please plan to do so at the time of your appointment:

- Primary care physician's full name, address, telephone and fax numbers.
- Referring physician's full name, address, telephone and fax numbers.
- MRI reports and films/CD's; CT reports and films/CD's
- Any other reports pertaining to your care.

***Very Important:** Do **not** bring your own medication list. Please fill out the medication list our office has provided for you in this New Patient packet. This form is specifically designed to aid our providers in providing you the best possible care

If you have any questions or concerns regarding any of the requested documents, anything pertained in your New Patient packet, or if you have general questions regarding our practice, please do not hesitate to call our office prior to your appointment. You may also visit our website at www.movementdisorderscenter.org to learn more about our clinic and our staff.

Sincerely,

RMMDC Providers, Management, & Staff

ROCKY MOUNTAIN MOVEMENT DISORDERS CENTER

Rajeev Kumar, M.D.
Medical Director

Vicki Segro, M.S.N., A.N.P
Nurse Practitioner

Josette Pressler, L.P.N.

Breanna Nickels, CCRC
Research Coordinator

Christina Reeves, BS
Research Coordinator

Courtney DesMarteau, MS
Research Coordinator

National Parkinson Foundation Care Center

PARKINSON FOUNDATION

Huntington's Disease Society of America Center of Excellence

Huntington's Disease Society of America

701 East Hampden Avenue
Suite 510
Englewood CO 80113-2759
(303) 357-5455 Phone
(303) 357-5459 Fax
www.movementdisorderscenter.org

Rocky Mountain Movement Disorders Center, P.C.

701 E Hampden Ave, Ste. 510 Englewood CO 80113
(303) 357-5455 Fax: (303) 357-5459

Patient Demographic Information

Patient Name:_____ DOB_____ Gender: M / F

Social Security #:_____-_____-_____ Marital Status_____

Mailing address_____

City_____ State_____ Zip _____

Phone # _____ Cell Phone _____ Work Phone_____

Email address _____

(*We do not sell, or advertise your email address to any other firm – This is for our Patient Portal purposes*)

Primary Care Physician (PCP)_____ PCP Phone_____

Address _____

PCP Fax _____ _____

Referring Physician _____ Ref. Phys Phone_____

Address_____

Ref Phys Fax _____

Pharmacy_____ Pharmacy Phone _____ Fax_____

Address_____

Employment Status: FT/PT/Student/Retired/Unemployed Employer_____

Emergency Contact_____ Relationship_____

Emergency Contact Phone_____ Cell Pone_____ Work _____

Insurance Information

Primary Insurance Company_____ ID# _____

Group # _____ Primary Insured's Name _____

Primary Insured's DOB_____

Secondary Insurance Company_____ID# _____

Group # _____ Primary Insured's Name _____

Primary Insured's DOB _____

****

Please read and sign the following Assignment of Benefits.

I hearby authorize assignment of benefits directly to Rocky Mountain Movement Disorders Center, P.C. for all my insurance claims related to services provided to me. I agree to pay all charges that exceed my insurance coverage and/or charges not covered by my insurance carrier.

I understand that copayments, deductibles, and non-covered services are due at time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance carrier.

I permit a copy of this authorization to be used in place of the original.

Signature_____ Date_____

Rocky Mountain Movement Disorders Center, P.C.

Patient Authorization for the Use & Disclosure of Protected Health Information

I hereby give my consent to Rocky Mountain Movement Disorders Center, P.C. (RMMDC) to use and disclose protected healthcare information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I also hereby give my consent for treatment by the physicians of RMMDC.

I have the right to review the Notice of Privacy Practices prior to signing this consent and any time thereafter.

With this consent RMMDC may do the following: *(Please select yes or no from each statement below)*

- May call my home and leave message on voicemail: Yes ◯ No ◯
- May call my place of employment and leave message on voicemail: Yes ◯ No ◯
- May call my cell phone and leave message on voicemail: Yes ◯ No ◯

Give authorization for review of my medical records to all appropriate clinic personnel regarding clinical trials. (For complete description, please see receptionist for a copy of our Notice of Privacy Practices/HIPAA).

Please list the individuals with whom we may communicate regarding your treatment at RMMDC, (i.e. family members, caregivers, etc.). Please list alternative phone numbers for family members if necessary.

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

By signing this form, I am consenting RMMDC's use and disclosure of my PHI to carry out TPO. I understand that this form will remain in effect until revoked. I may revoke or change my consent at any time.

Patient Name (please print) Patient (or responsible party) Signature

Responsible Party Name (Please Print) Date

ROCKY MOUNTAIN MOVEMENT DISORDERS CENTER, P.C.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice , please contact the Privacy Officer for Rocky Mountain Movement Disorders Center, P.C.
(303) 357-5455

Introduction

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

At Rocky Mountain Movement Disorders Center, P.C. (RMMDC), we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information

Each time you visit RMMDC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, and serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of RMMDC, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and obtain a copy your health record as provided for in 45 CFR 164.524,
- Request to Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Rocky Mountain Movement Disorders Center is required to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction,
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location, and
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

RMMDC, reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.
Examples of How the RMMDC, May Use or Disclose Your Health Information

For Treatment: RMMDC, may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to those actions.

For Payment: RMMDC may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For health care operations: For example, Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointments: RMMDC, may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Business associates: Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we may use your name, if you have been transported to a hospital or other facility, and give your general condition, and religious affiliation for directory purposes. This information may be provided to family members or members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification, or Communication with Family Members: Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons' involvement in your care or payment information related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant

Marketing: We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by Law: Rocky Mountain Movement Disorders Center, P.C., may use and disclose information about you as required by law. For example, Rocky Mountain Movement Disorders Center, P.C., may disclose information for the following purposes:

for judicial and administrative proceedings pursuant to legal authority;
to report information related to victims of abuse, neglect or domestic violence; and
to assist law enforcement officials in their law enforcement duties.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

For More Information or to Report a Problem, or If you have questions and would like additional information, you may contact our practice's Privacy Officer.

Rocky Mountain Movement Disorders Center, P.C.
701 E Hampden Ste 510
Englewood, CO 80113
Phone (303) 357-5455 Fax (303) 357-5459

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer in writing, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights - U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY

Acknowledgment of Receipt of this Notice

Rocky Mountain Movement Disorders Center, P.C. is concerned about the privacy of our patients health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:
Rocky Mountain Movement Disorders Center, P.C.

Name of Patient (PRINT)_____

_____ _____
Signature of Patient or Authorized Representative Date

In accordance with the HIPPA guidelines this practice is authorized to discuss my medical information with the following individuals.

Name	Relationship	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Rocky Mountain Movement Disorders Center, P.C.
Rajeev Kumar, M.D.
701 E. Hampden Ave Suite 510
Englewood CO 80113

Financial Policy/Consent for Payment

I understand that my insurance company may or may not pay for services rendered to me by Rocky Mountain Movement Disorders Center, P.C. (RMMDC) I also understand that I am responsible for copayments, co-insurance amounts, and any in/out of network deductibles that I may owe. I am also responsible for any referrals and pre-authorizations required by my insurance carrier(s).

I agree to be 100% responsible for payment if my insurance denies reimbursement for my claims. An authorization, pre-certification, or verification of eligibility is not a guarantee of payment.

All payments will be made to RMMDC by cash, check, or a major credit card.

It is the policy of RMMDC to hold a valid credit card number (Please see attached form). I understand that if I fail to comply with this policy, I may be denied treatment or care from RMMDC. I further understand that RMMDC may automatically bill my credit card for my unpaid account balances over 90 days old.

Hospice Patients

If you are currently under Hospice care: Please be advised that unless you have pre-arranged the visit to our clinic with your hospice provider, your visit will not be covered by your insurance carrier and you will be responsible for all charges incurred.

Payment Arrangements and Expectations

Rocky Mountain Movement Disorders Center, P.C., requires payment due at the time services are rendered. In the event you need to make special payment arrangements, our policy is to collect payment in-full within three (3) months. If your account becomes delinquent and we are unable to collect your debt, we may transfer your account to an outside collection agency. Should your account be transferred to a collection agency, you will be responsible for any associated collection fees and you may also be discharged from treatment and care from RMMDC.

No-Show, Cancelation, and Administrative Fees

There may be a $75.00 fee assessed to your account if you fail to call and cancel your appointment within 48 hours of your scheduled appointment time. There will also be a $75.00 fee assessed to your account if you fail to show up for your appointment.

Our office may also charge the following Administrative Fees:

- Returned checks: $30.00
- Completion of forms: $50.00
- Medical Records: $25.00

The financial and insurance information provided by me to RMMDC is true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney fees and cost of collection, in the event of account default. I also authorize RMMDC to furnish or obtain any/all information to/from insurance carriers, Social Security Administration (Medicare), the referring physicians, or other agencies to which RMMDC refers and designated family members or caregivers concerning my illness and treatments. I authorize my insurance company to send claim payments directly to RMMDC. I further understand that this signed policy will remain in effect until revoked.

_____ _____

Patient Name (Please Print) Patient (or responsible party) Signature

_____ _____

Responsible Party Name (Please Print) Date

Rocky Mountain Movement Disorders Center, P.C.
Rajeev Kumar, M.D.
701 E. Hampden Ave Suite 510
Englewood CO 80113

Credit Card on File

As stated in the Financial Policy of Rocky Mountain Movement Disorders Center, P.C. (RMMDC), It is the policy of RMMDC to withhold a valid credit card number.

I understand that if I fail to comply with this policy, I may be denied treatment or care from RMMDC. I further understand that RMMDC may automatically bill my credit card for my unpaid account balances over 90 days old.

I am aware that RMMDC may charge my card $0.01 for verification purposes. I am also aware that RMMDC will keep my credit card information private and secure. At no time will RMMDC share my credit card information with any outside agencies. This contract will remain in effect until the card on file expires, at which time it is my responsibility to provide a new card to RMMDC.

_____
Patient Name

_____ _____
Name on Card **Card Type**

_____ _____
Card Number **Expiration Date**

_____ _____
Security code on back of card **Billing Zip Code**

_____ _____
Signature **Date**

Rocky Mountain Movement Disorders Center, P.C.
701 E Hampden Ave Ste 510
Englewood CO 80015

Medication List

Rajeev Kumar, M.D.
Vicki Segro, MSN C-ANP
Phone (303)357-5455
Fax (303)357-5459

Please write the quantity of tablets taken at each time frame
(ie. 2 tablets taken at 8am, note the number 2 in the 8AM box)

Patient Name:_____

Date of Birth:_____

Date:_____

Please fill out all *non-prescription* drugs and supplements on the back

Pharmacy Information- **Local:** **Mail Order:**

Prescription Medications	**Strenght**	**Form**	12AM	1AM	2AM	3AM	4AM	5AM	6AM	7AM	8AM	9AM	10AM	11AM	NOON	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM
Example	40 mg	capsule									2				1								1			
List all medications prescribed by our office first																										

Rocky Mountain Movement Disorders Center, P.C.
701 E Hampden Ave Ste 510
Englewood CO 80015

Medication List

Rajeev Kumar, M.D.
Vicki Segro, MSN C-ANP
Phone (303)357-5455
Fax (303)357-5459

Non-Prescription Drugs and Vitamins/Supplements

Medication/Supplements	**Strenght**	**Form**	12AM	1AM	2AM	3AM	4AM	5AM	6AM	7AM	8AM	9AM	10AM	11AM	12PM	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM

REVIEW OF SYSTEMS

RESPIRATORY HISTORY:

1. Shortness of breath? YES☐ NO☐
2. Do you have a cough? YES☐ NO☐
3. Sputum production? YES☐ NO☐
4. Are you coughing up blood? YES☐ NO☐
5. Do you have any chest pain? YES☐ NO☐
6. Do you have a sore throat? YES☐ NO☐
7. Have you had/have a change in your voice? YES☐ NO☐
8. Diagnosis of Asthma, COPD, Pulmonary Embolism? YES☐ NO☐
9. Do you have seasonal allergies? YES☐ NO☐

GENERAL HISTORY:

1. Change in weight gain/loss? YES☐ NO☐
2. Are you experiencing fever/chills? YES☐ NO☐
3. Are you experiencing night sweats? YES☐ NO☐
4. Are you experiencing leg swelling? YES☐ NO☐

SLEEP HISTORY:

1. Any history of snoring? YES☐ NO☐
2. Daytime sleepiness? YES☐ NO☐
3. Daytime fatigue? YES☐ NO☐
4. Morning headache? YES☐ NO☐
5. Complaint from bed partner? YES☐ NO☐
6. Need for sleeping aid? YES☐ NO☐
7. Diagnosis of sleep apnea? YES☐ NO☐
8. Use of a CPAP/BiPAP/O_2? YES☐ NO☐
9. Accidents/Job performance? YES☐ NO☐
10. How well do you sleep at night?_____

SOCIAL HISTORY:

1. Smoking history: Active/Ex-smoker YES☐ NO☐
2. Alcohol use? ☐ YES☐ NO☐
3. Do you live: Alone With Spouse With Family Facility?
4. Occupation:_____ Retired: YES☐ NO☐

FAMILY HISTORY:

1. Heart disease/Stroke YES☐ NO☐
2. Diabetes YES☐ NO☐
3. Asthma/Allergies YES☐ NO☐
4. Sleep disorder YES☐ NO☐
5. Pulmonary disease YES☐ NO☐
6. Malignancies YES☐ NO☐

Previous operations_____

_____

_____

Previous hospitalizations_____

_____

_____

Do you have a living will? YES☐ NO☐

REVIEW OF SYSTEMS:

1. Eyes, Ears, Nose YES☐ NO☐
   a. Vision problems/glasses YES☐ NO☐
   b. Nasal congestion/sinus/polyp YES☐ NO☐
   c. Hearing problems/Aids YES☐ NO☐

2. Cardiac YES☐ NO☐
   a. Chest pain/Heart attack YES☐ NO☐
   b. History of congestive heart failure YES☐ NO☐
   c. History of heart surgery YES☐ NO☐
   d. High blood pressure YES☐ NO☐
   e. Palpitations/Blackout spells YES☐ NO☐
   f. Blood clots/Anticoagulation therapy YES☐ NO☐

3. Gastrointestinal YES☐ NO☐
   a. History of ulcers YES☐ NO☐
   b. History of heartburn YES☐ NO☐
   c. Difficulty swallowing YES☐ NO☐
   d. Vomiting blood or blood in stool YES☐ NO☐
   e. Constipation or diarrhea YES☐ NO☐

4. Genito-Urinary Tract YES☐ NO☐
   a. Kidney disease YES☐ NO☐
   b. Urinary infections YES☐ NO☐
   c. Incontinence YES☐ NO☐
   d. Prostate disease YES☐ NO☐

5. Musculoskeletal YES☐ NO☐
   a. Arthritis YES☐ NO☐
   b. Muscle or Joint pain YES☐ NO☐
   c. Gout YES☐ NO☐

6. Hematology/Lymphatic YES☐ NO☐
   a. Anemia YES☐ NO☐
   b. Bleeding disorder YES☐ NO☐
   c. Cancer YES☐ NO☐
   Where_____ When_____

7. Neurologic YES☐ NO☐
   a. Chronic headaches YES☐ NO☐
   b. Stroke YES☐ NO☐
   c. Seizure disorder YES☐ NO☐
   d. Numbness/Tingling YES☐ NO☐
   e. Weakness YES☐ NO☐

8. Skin YES☐ NO☐
   a. Skin rash YES☐ NO☐
   b. Eczema YES☐ NO☐
   c. Psoriasis YES☐ NO☐

9. Psychiatric YES☐ NO☐
   a. Anxiety YES☐ NO☐
   b. Depression YES☐ NO☐
   c. Any treatment Active/Past YES☐ NO☐

10. Endocrine YES☐ NO☐
    a. Thyroid problems YES☐ NO☐
    b. Diabetes YES☐ NO☐

Patient Medical History

Name_____ DOB_____ Age_____

Occupation and employer (Current or most recent) _____

If currently working:

Height_____ Weight_____

Allergies to Medications_____

_____

Right Handed_____ Left Handed_____

Reason for today's visit_____

_____

_____

Please check any of the following conditions you currently have or have had in the past:

Diabetes_____	Cancer_____	Asthma_____
High blood pressure_____	Kidney disease_____	Heart problems_____
Heart attack_____	Liver disease_____	Other lung disease_____

Please list any other current or past medical problems:_____

_____

_____

_____

Surgical history: *Please list all prior surgery and date of surgery*

Please check any of the following that you have had:

Gall bladder removal_____	Bladder surgery_____	Shoulder surgery_____
Appendix removal_____	Hysterectomy_____	Cervical spine (neck) surgery___
Tonsil removal_____	Prostate surgery_____	_____
Cataract surgery_____	Knee surgery_____	Lumbar spine (low back)_____
Heart surgery_____	Hip surgery_____	_____

Please list any other surgeries you have had and when you had them_____

_____

_____

_____

Family Medical History

Patient name_____ Date_____

Please list all family medical conditions – If family member is deceased, please state:

Father_____

_____

Mother_____

_____

Sisters_____

_____

_____

_____

Is there anyone amongst your immediate and/or distant family members with Parkinson's disease, Tremor, dystonia, tics, Tourette's syndrome, or any other involuntary movement disorder?_____

_____

_____

Is there anyone else in your family with other neurological conditions?_____

_____

_____

Is there anyone amongst your immediate or distant family members with Alzheimer's disease, or any other form of dementia, senility, or trouble thinking in old age?_____

_____

Do you have any other significant family history medical conditions?_____

_____

Do you currently smoke? Yes____ No____ Packs per day?_____ How long have you smoked?_____

Did you previously smoke? Yes____ No____ Packs per day?____ How long did you smoke?_____

How often do you drink alcohol? Never____ Occasionally____ Frequently____

Do you use marijuana? Yes____ No____ Do you currently or did you in the past, use any other drugs such as cocaine, amphetamines, methamphetamines, LSD, PCP, barbiturates, etc?_____

Please provide the name, phone number, and fax numbers of the providers you would like us to submit our reports to:_____

_____

_____

_____

_____