NEWPORT BEACH NEUROLOGY CENTER
PATIENT INTAKE FORM
Dr. Valerie Acevedo
(Please Print)

DATE:_____

PATIENT INFORMATION				
First Name: (Print Below)	Last Name:	☐Male ☐Female	DOB:	AGE:
Home Address:	City:		State:	ZIP Code:
Social Security # (optional):	Home Phone #:		Cell Phone #:	
Occupation:	Employer:		Employer's Phone Number: ( )	
Referred By:				
PATIENT E-MAIL:				

PREFERRED PHARMACY INFORMATION		
Pharmacy Name:		
Address:	City:	Zip Code:
PHARMACY PHONE #:		

EMERGENCY CONTACT INFORMATION		
Name of local friend or relative:	Relationship to patient:	PHONE NUMBER:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Valerie Acevedo or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Date: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name: _____ DOB: _____/_____/_____ AGE: _____

Please list your doctors (starting with your Primary Care Physician):

Doctor(s):	Specialty:
_____	_____
_____	_____
_____	_____
_____	_____

CHIEF COMPLAINT

Reason for today's visit? _____

When did your symptoms first begin?

Today your symptoms are: ☐ The Same ☐ Better ☐ Worse

PERSONAL HEALTH HISTORY

Past Medical History:

☐ High Blood Pressure	☐ Prior Heart Disorder	☐ High Cholesterol
☐ Diabetes	☐ Seizure Disorder	☐ Thyroid Disorder
☐ Prior Stroke	☐ Migraines	☐ Other:

Surgeries:

Year(s):	Operation(s):	Doctor(s):

Hospitalizations:

Year(s):	Reason(s):

List Of Medications & Vitamins:

Name of Drug:	Amount:	Name of Drug:	Amount:
1.)		5.)	
2.)		6.)	
3.)		7.)	
4.)		8.)	

SOCIAL HISTORY

Marital Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed □ Widower

Education: □ GS □ HS □ GED □ College □ Postgraduate
Work History: Jobs held in past:_____ Current job:_____

Caffeine: □ None □ Coffee □ Tea □ Cola # of Cups/Cans Per Day? _____

Alcohol: Do you drink alcohol? □ Yes □ No If yes, what kind?_____ How many drinks per week? _____

Drugs:
Do you currently use recreational or street drugs (cocaine, methamphetamine, marijuana, etc)? … □ Yes □ No

Tobacco:
Do you use tobacco? □ Yes □ No □ Cigarettes - Pks/day_____ □ Chew - #/day _____
□ # of Years _____ □ or Year Quit _____

Toxic exposures: please list any (lead, arsenic, solvents, mercury, etc) _____

ALLERGIES TO MEDICATIONS

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Brothers and Sisters	□ M □ F		
	□ M □ F		
	□ M □ F		
	□ M □ F		
	□ M □ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children			
	□ M □ F		
	□ M □ F		
	□ M □ F		
	□ M □ F		
	□ M □ F		

REVIEW OF SYSTEMS:

GENERAL

Have you had recent fever? ..... □ Yes □ No
Have you had recent weight loss?..... □ Yes □ No
Do you have frequent / severe night sweats? ..... □ Yes □ No

ENDOCRINE

Do you have thyroid problems or goiter? ..... □ Yes □ No
Do you have diabetes? ..... □ Yes □ No

More on next page

HEAD, EYES, EARS, NOSE, AND THROAT

Do you have vision (eyesight) problems?	☐ Yes	☐ No
Do you have dry eyes?	☐ Yes	☐ No
Do you have trouble hearing?	☐ Yes	☐ No
Do you have ringing in your ears?	☐ Yes	☐ No
Do you have nosebleeds?	☐ Yes	☐ No
Do you have hoarseness?	☐ Yes	☐ No
Do you have sinus problems?	☐ Yes	☐ No
Do you have dry mouth?	☐ Yes	☐ No

GASTROINTESTINAL

Do you have trouble swallowing?	☐ Yes	☐ No
Do you have indigestion or heartburn?	☐ Yes	☐ No
Have you had ulcers?	☐ Yes	☐ No
Do you have frequent constipation?	☐ Yes	☐ No
Do you have frequent diarrhea?	☐ Yes	☐ No
Have you had hepatitis or liver disease (yellow jaundice)?	☐ Yes	☐ No
Do you have gallbladder disease?	☐ Yes	☐ No
Are you on a special diet? _____	☐ Yes	☐ No

PULMONARY

Do you have shortness of breath?	☐ Yes	☐ No
Do you have wheezing, asthma, or emphysema?	☐ Yes	☐ No
Have you had tuberculosis or a positive TB test?	☐ Yes	☐ No

CARDIOVASCULAR

Do you have hypertension (high blood pressure)?	☐ Yes	☐ No
Do you have heart disease (heart attack, heart failure, valve problem)?	☐ Yes	☐ No
Do you have a heart murmur?	☐ Yes	☐ No
Does your heart beat fast or slow (palpitations)?	☐ Yes	☐ No
Do you have high cholesterol?	☐ Yes	☐ No

NEUROLOGIC

Do you have headaches?	☐ Yes	☐ No
Have you ever had a seizure or convulsion?	☐ Yes	☐ No
Do you have a loss of sensation (numbness) anywhere?	☐ Yes	☐ No
Do you have a loss of muscle power anywhere?	☐ Yes	☐ No
Do you have tremor (shaking)?	☐ Yes	☐ No
Have you had a concussion or whiplash injury?	☐ Yes	☐ No
Do you have trouble sleeping? If so, what trouble?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you have trouble walking?	☐ Yes	☐ No
Do you have trouble with your speech?	☐ Yes	☐ No
Do you have frequent dizziness?	☐ Yes	☐ No
Do you have motion sickness?	☐ Yes	☐ No
Do you have double vision?	☐ Yes	☐ No
Have you ever had a stroke?	☐ Yes	☐ No

More on next page

HEMATOLOGIC

Do you bleed or bruise easily? ☐ Yes ☐ No
Do you have anemia (low blood count)? ☐ Yes ☐ No
Do you have a history of B12 deficiency or Iron deficiency? ☐ Yes ☐ No

RHEUMATOLOGIC

Do you have a history of any rheumatologic disease (Lupus, Sjogrens, Rheumatoid)? ☐ Yes ☐ No
Do you have arthritis or joint pain/swelling? ☐ Yes ☐ No
Do you have back or neck pain? ☐ Yes ☐ No

DERMATOLOGIC

Do you have any skin problems (rashes, acne, moles, etc)? ☐ Yes ☐ No
Have you had malignant melanoma? ☐ Yes ☐ No
Have you had any other form of skin cancer? ☐ Yes ☐ No

PSYCHOLOGIC

Is stress a major problem for you? ☐ Yes ☐ No
Do you feel depressed? ☐ Yes ☐ No
Do you panic when stressed? ☐ Yes ☐ No
Do you have problems with eating or your appetite? ☐ Yes ☐ No
Do you cry frequently? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No

What degree of stress do you have:
At Home? _____
At Work? _____
Other? _____

WOMEN ONLY-GENITOURINARY

Number of pregnancies _____ Number of live births _____
Have you ever had a miscarriage? ☐ Yes ☐ No
Are you pregnant or breastfeeding? ☐ Yes ☐ No
Have you had a hysterectomy? ☐ Yes ☐ No
Have you had any bladder problems in the past year? ☐ Yes ☐ No
Any problems with control of urination? ☐ Yes ☐ No
Have you had kidney disease? ☐ Yes ☐ No

MEN ONLY-GENITOURINARY

Do you usually get up to urinate during the night? ☐ Yes ☐ No.....If yes, # of times _____
Do you have any bladder problems? ☐ Yes ☐ No
Any difficulty with erection or ejaculation? ☐ Yes ☐ No
Do you have any prostate problems? ☐ Yes ☐ No
Have you had kidney disease? ☐ Yes ☐ No

DOCTOR'S REVIEW

This form was reviewed with patient.

_____ _____/_____/_____
Physician Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitration: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to a court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be our arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator

The parties consent to the intervention and joined in this arbitration of any person or entity which would otherwise be a proper additional party in court action, and upon such intervention and joined or any existing court action against such additional person or entity shall be stayed in pending arbitration.

The parties agree that the provisions of California law applicable to healthcare provider shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based on the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedures provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of the signature. It is the intent of this agreement to apply all medical services rendered at any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of the other provision.

I understand that I have the right to receive a copy of this arbitration agreement by my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS

By: _____ _____

Patient's or Patient's Representative's Signature Date

By: _____ _____ By: _____

Physician's or Authorized Representative's Signature Date Print Patient's Name

_____ _____

Print or Stamp Name of Physician, Medical Group, or Association Name (If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.