POST-HOSPITAL NEURO EVALUATION 2023

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SELSON CLINICS NEUROLOGY
SELWYN-LLOYD Mc PHERSON MBBS, MD

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Website: selsonclinicsneuro.com

PATIENT'S PERSONAL INFORMATION

DATE:

REFERRED BY:

PATIENT NAME:

GENDER: **DATE OF BIRTH:** **SOC SEC NUMBER (last 4 numbers)::** **MARITAL STATUS:**

ADDRESS:

STREET ADDRESS:

CITY/STATE/ZIP:

CELLPHONE: _____HOME PHONE: _____EMAIL_____

RELATIONSHIP TO YOU: **PHONE NUMBER:**

NAME OF PERSON TO CALL IN CASE OF EMERGENCY:

PHONE NUMBER OF PERSON TO CALL IN CASE OF EMERGENCY:

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:

ID#: **PHONE NUMBER:**

SUBSCRIBER NAME: **SUBSCRIBER DATE OF BIRTH:**

SECONDARY INSURANCE NAME:

ID#: **PHONE NUMBER:**

SUBSCRIBER NAME: **SUBSCRIBER DATE OF BIRTH:**

TO PAY BENEFITS TO SELSON CLINICS , INC.

In order to control the cost of billing, we request that our charges for office visits or any co-pays be paid in full, before each visit.

The responsibility for paying for the services provided, lies with you the patient, even if you have insurance coverage for our inpatient and outpatient health care services. Some companies pay fixed allowances for certain procedures, and it is your responsibility to pay for any deductible amount or any other balances not paid for by your insurance.

I hereby assign to Selson Clinics Inc., all medical and laboratory benefits rendered by Selson Clinics Neurology, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health care plans. This assignment (responsible party) is responsible for all charges whether or not paid by insurance. I hereby authorize the assignee, Selson Clinics Neurology, to release all information necessary to secure payment.

RESPONSIBLE PARTY SIGNATURE:_____
RESPONSIBLE PARTY NAME:_____DATE:

PLEASE LIST THE NAMES OF THE PHYSICIANS OR OTHER AUTHORIZED PERSONS TO WHOM WE SHOULD SEND COPIES OF THIS INITIAL ASSESSMENT, FOLLOW-UP ASSESSMENTS AND LAB REPORTS.

PLEASE SUPPLY ALL REQUESTED INFORMATION.

PHYSICIAN
Name:
Phone: **Fax:**

PHYSICIAN
Name:
Phone: Fax:

PATIENT'S SIGNATURE: DATE:

PRESCRIPTION DRUG HISTORY

PATIENT NAME:

I am giving my permission for Dr. McPherson and his staff at Selson Clinics Neurology, to electronically review my prescription history, including but not limited to narcotics, benzodiazepines, psychotropic and stimulant drugs

PATIENT'S SIGNATURE: _____ DATE:

PLEASE SUPPLY ALL REQUESTED INFORMATION.

PHYSICIAN
Name:
Phone: Fax:

PHYSICIAN
Name:
Phone: Fax:

PATIENT'S SIGNATURE: DATE:

PRESCRIPTION DRUG HISTORY

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PATIENT'S SIGNATURE: _____ DATE:

MEDICATION HISTORY
(Include all over-the-counter drugs including vitamins, antacids, and aspirin products)

NAME OF MEDICATION	DOSE	FREQUENCY	CONDITION

NAME OF OVER-THE-COUNTER DRUGS DOSE FREQUENCY CONDITION

DRUG ALLERGIES

_____

_____

_____

PHARMACY **FAX** **PHONE:**

DATE OF HOSPITALIZATION:

NAME OF HOSPITAL:

DURATION OF HOSPITALIZATION:

REASON FOR HOSPITALIZATION:

OTHER COMMENTS