



Michigan Advanced Neurology Center

Debasish Mridha, M.D.

4705 Towne Centre, Ste. 201•Saginaw, MI 48604

Telephone (989) 799-2770•Fax (989) 799-2737

PATIENT REGISTRATION

(PLEASE PRINT)

Patient Name _____

Responsible Party (if minor) _____

If pt is a minor: Mother's DOB _____ Father's DOB _____

Street Address _____ Apt. _____ Phone (____) _____

City _____ State _____ Zip _____

Sex: Male ___ Female ___ Marital Status: M ___ S ___ W ___ D ___ Birthday ___/___/___ Age _____

Social Security _____ Spouse's Social Security _____

Patient Employer _____ Phone _____

Primary Insurance _____

Contract or ID# _____ Group _____

Subscriber _____ Subscriber's DOB _____

Secondary Insurance _____ Contract # _____

Subscriber _____ Subscriber's DOB _____ Group _____

Is this a work or auto claim? Yes ___ No ___ Claim # _____

Work/Auto Insurance _____

Contact Person _____ Phone (____) _____

Emergency Contact (other than spouse) _____

Phone (____) _____ Work/ Cell Phone (____) _____

Referring Physician _____ Phone (____) _____

Primary Care Physician _____ Phone (____) _____

ASSIGNMENT OF RELEASE:

I authorize any holder of medical or other information about me to release to all carriers any information needed for this or any other related medical insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. I understand I am financially responsible for all charges whether or not paid by insurance.

Signature of Insured/Guardian

Date



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STATEMENT OF DISCLOSURE

Patient Name: _____ Birthdate: _____

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize Debasish Mridha, M.D. and staff to provide my medical records, mental health therapy or treatment/counseling records, alcohol treatment records, and/or substance abuse records, make a full oral or written report to:

- Authorization of any and all family members
- Do not disclose medical information to anyone but myself
- Disclose medical information only to the following people:
(Please include any physicians that you would like a copy of reports sent to)

Name: _____

Relationship: _____ Telephone Number: _____

Name: _____

Relationship: _____ Telephone Number: _____

Name: _____

Relationship: _____ Telephone Number: _____

This authorization will expire: _____ at the end of treatment _____

(Expiration Date or Defined Event)

I further request that you permit such records be copied or Photostat or otherwise. A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Signature

Date



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Name _____ Age ____ M F Date _____

HISTORY OF PAST ILLNESS:

- Cancer
- Diabetes Mellitus (Sugar Diabetes)
- Epilepsy
- Heart Disease
- High Blood Pressure
- Mental Illness
- Stroke
- Others _____

LIST ANY HOSPITALIZATIONS AND REASONS:

FAMILY HISTORY:

Family Member	Age	Health	Age @ Death	Cause of Death
Father				
Mother				
Brother/Sister				
Children				
Grandparents				

ALLERGIES:

- Penicillin Sulfa
- Antibiotics Seizure Meds
- X-ray Dye Sedatives
- Other _____

SOCIAL HISTORY:

Circle One: Single Married Separated
 Divorced Widowed Significant Other

With whom do you live with: _____

Recreational Drug Usage? No Yes

Coffee ____ Tea ____ Colas ____ (per day)

Alcohol: Never ____ <1 per week ____
 1-5 per week ____ Other ____

Tobacco: Never Smoked Quit ____ yrs ago
 # yrs Smoked ____ Packs per day ____

Highest Education Completed: _____

SYSTEMIC REVIEW

GENERAL:

- Headache
- Lethargy/Weakness
- Chills
- Night Sweats
- Fever
- Fainting/LOC
- Dizziness
- Recent weight change
Gain Loss

EYES:

- Wears glasses
- Eyesight worsening
- Double vision
- Eye pain

EAR/NOSE/THROAT:

- Deafness
- Noise in ears
- Congestion
- Sinus trouble
- Nose bleeds
- Sore throat
- Hoarse voice

HEART:

- Chest Pain
- Heart Murmur
- Palpitations
- High Blood Pressure
- Swollen Feet/Ankles

LUNG:

- Pneumonia
- Shortness of breath

STOMACH:

- Recent bowel changes
- Diarrhea
- Liver disease
- Irritable bowel syndrome

KIDNEY/BLADDER/PROSTATE:

- Frequent urination
- Burning with urination
- Difficulty starting urine
- Dribbling
- Sex difficulties

Prostate disease

INFECTIONS:

- Cancer
- Meningitis

BREAST/MENSTRUAL:

- Menstrual irregularity
- Endometriosis
- # of pregnancies ____

SKIN:

- Rash
- Sores
- Dry skin
- Oily skin
- Bruise easily
- Bleeds easily

MUSCULOSKELETAL:

- Back pain
- Neck pain
- Difficulty walking
- Arthritis
- Fibromyalgia
- Aching muscles/joints

NEUROLOGY:

- Memory problems
- Numbness
- Tingling
- Light headedness

PSYCHIATRY:

- Cry often
- Depressed
- Worry a lot
- Considered suicide
- Loss of interesting in eating
- Anxiety/Tension
- Loss of energy
- Fatigue
- Panic attack

ENDOCRINE:

- Tired
- Weak
- Thirsty
- Diabetes

SLEEP:

- Snore
- Hold breath
- Gasp in sleep

- Restless sleep
- Insomnia
- Sleep walk
- Sleep talk
- Leg twitching