# 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