637 West Avenue, Suite 200
Norwalk, CT 06850
(203) 853-5000 phone
(203) 853-5001 fax
NorwalkNeurology.com

Louis J. Cuzzone, MD
Irina Taraban, MD
Daryl R. Story, MD
James L. Thompson, Jr., MD

Welcome to Neurology Associates of Norwalk. We are looking forward to seeing you at your appointment! We will call you 3 business days prior to confirm this appointment. **It is important that we hear from you to confirm.** If we do not reach you during that call, please return our call to confirm your appointment. Please be sure your phone number(s) are accurate, in service and have working voicemail so we may reach you. If we do not hear from you by noon of the prior business day, we will have to reschedule your appointment. All future appointments will be confirmed with a phone call from our automated system.

Please arrive 5 – 10 minutes early for your first appointment with us. We are located on the 2nd floor above the Wells Fargo bank. Be sure to bring your medical insurance card(s) and photo identification. If you were provided with an electronic insurance card, please print a paper copy to present to our office at check in. Enclosed is a copy of our demographics and intake forms. If possible, please mail or fax this completed form to us prior to your appointment. Please include a list of all medications you are taking, including strength and dosing frequency, or be sure to complete that section on your new patient form. Also supply us with any relevant medical records prior to this visit. Doctor's notes, MRIs and other testing are crucial to a productive first visit and managing your care. If you are not able to fax or mail this information prior to your appointment, please be sure to arrive 15 minutes early and bring this **completed** information with you.

If you need to cancel or reschedule your appointment, please give us as much advanced notice as possible. Missed or cancelled appointments with less than 24 hours' notice, excluding weekends and holidays, will be charged a $50 fee. Thank you for giving us the opportunity to see you and trusting your care to Neurology Associates of Norwalk.

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2020 Intake & Demographics Form

Patient name: _____ **Date of Birth:** _____ **Gender:** Male Female

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email: (complete only to be enrolled in our Patient Portal) _____

What is your marital status? Single Married Divorced Widowed Domestic Partner **Preferred language:** English or other: _____

Race: African American / Asian / Caucasian / Native American / Pacific Islander **Ethnicity**: Hispanic or Latino / not Hispanic or Latino

Primary Care Doctor: _____ **Referring Doctor:** _____

Primary Medical Insurance: _____ **Policy #:** _____ **Group #:** _____

Secondary Medical Insurance: _____ **Policy #:** _____ **Group #:** _____

Guarantor (person financially responsible for paying and medical bills) **LEAVE BLANK IF PATIENT IS GUARANTOR**

Guarantor name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Guarantor signature: _____ **Relationship:** _____

Emergency contact name:_____ **Phone number**:_____

Patients often give us permission to discuss information with family or other individuals. If you want us to be able to talk to someone, we need to verify your permission. If you don't give permission for us to talk to anyone, leave it blank. Neurology Associates of Norwalk has my consent to communicate with the following person and/or discuss my personal medical information with the following person.

Name(s):_____ **Relationship(s):**_____

Name(s):_____ **Relationship(s):**_____

Name(s):_____ **Relationship(s):**_____

The information I have provided above is complete and accurate to the best of my knowledge. I have read and understand the Notice of Privacy Practices as well as the Office Policies for Neurology Associates, PC.

Patient signature: _____ **Date:** _____

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Patient name:_____ **Date of Birth:**_____

Primary Care Physician: _____ **City & State:** _____

Referring Physician: _____ **City & State:** _____

Explain the problem that prompted this visit to a neurologist: _____

_____

Onset/duration:_____

What treatments have you had for this problem? _____

_____

What tests have been done for this problem? _____ **Where?**_____

What is your height? _____ft_____inches. **What is your weight?** _____ lbs **Are you:** right-handed /left-handed / ambidextrous (both)

Medical problems: Please circle any medical problems you have had or currently have or please list if you have a condition that is not included

Neurological: Migraines Multiple Sclerosis Neuropathy Parkinson's disease Seizures Concussion Stroke TIA intracerebral hemorrhage memory problems neck pain back pain sciatica learning disability other_____

Cardiovascular: High blood pressure coronary artery disease heart attack atrial fibrillation cardiac stent bypass graft Pacemaker Defibrillator peripheral vascular disease other_____

Respiratory: Asthma COPD emphysema lung cancer other_____

Endocrine: Diabetes hypothyroidism hyperthyroidism other_____

Gastrointestinal: Ulcers gastro esophageal reflux hepatitis colon cancer other_____

Hematologic: Anemia hemophilia leukemia lymphoma hypercoagulable state other_____

Psychiatric: Anxiety depression bipolar disorder ADHD schizophrenia substance abuse other_____

Musculoskeletal: Osteoarthritis rheumatoid arthritis osteoporosis osteopenia other_____

Cancer : chemotherapy radiation cancer surgery What type of cancer?_____

Eyes and ears: Cataract glaucoma vision loss lazy eye double vision hearing loss other_____

Previous surgeries: Tonsils appendix hysterectomy gallbladder hernia other_____

Review of systems: Please circle any symptoms you have recently had: Fever chills recent visual change cough shortness of breath chest pain change in bowel or bladder habits bleeding joint pain Rash headache other:_____

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Patient name:_____ **Date of Birth:**_____

Social History:

Alcohol use: Never Quit at _____age Currently drink _____ drinks per week or _____drinks per year.

Tobacco use: Never Quit at _____ age Currently smoke _____ pack(s) per day or _____ per year.

Any Illicit drug use?: _____

What is your occupation? Retired Student Homemaker On disability Employed as _____

Employer name:_____

Employer address:_____ _____

List any allergies to medications, Latex or contrast dye. ___ **No Known Allergies**

Medication or product	Reaction

Please give us a list of your current medications. Include over-the-counter medications, like aspirin, and supplements (continue on reverse if needed or attach a list) PLEASE WRITE CLEARLY.

Medication Name & Strength	Dose	When Taken

Preferred Pharmacy: _____ **City & Street:** _____

Family History: Are you adopted? Yes or No

Please list medical problems in your family members such as; migraine, stroke, high blood pressure, heart disease, neuropathy, dementia, and type of cancer, if any. **List cause of death , if known.**

Mother:_____

Father:_____

Brothers and sisters:_____

Other family members:_____