MIODRAG VELICKOVIC, M.D
1940 Commerce St. Suite 107 YORKTOWN HEIGHTS, NY 10598
TEL: 914-962-1000 FAX: 914-962-8267

CONSENT TO RECEIVE THE APPOINTMENT REMINDERS THROUGH MOBILE PHONE TEXT MESSAGING

____

Last name Middle name First name

Birth Date: / /

Mobile phone number: ________________________________

Patient's Signature:______________________________ **Date:_____________**

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PATIENT INFORMATION

NAME:______________________ DATE OF BIRTH:______________________

ADDRESS:______________________ CITY______________________ STATE__________ ZIP________

HOME PHONE:______________ WORK PHONE:______________ CELL PHONE:______________

RACE: American Indian/Alaska Native Asian Black/African American Native Hawaiian/ Pacific Islander White

ETHNICITY:______________ MARITAL STATUS: M S D W DP SEX: M F PRIMARY LANGUAGE:______________

EMPLOYER:______________________ OCCUPATION:______________________

SPOUSES NAME:______________________ EMERGENCYCONTACT:______________________

PHARMACY USED:____

INSURED INFORMATION

INSURED NAME:______________________ DATE OF BIRTH:______________________

ADDRESS:______________________ HOME PHONE:______________________

CITY:______________________ STATE:______ ZIP:________ SEX: M F RELATIONSHIP:__________

INSURANCE INFORMATION

PRIMARY INSURANCE:______________ IDENTIFICATION #:______________ GROUP #:______________

SECONDARY INSURANCE______________ IDENTIFICATION#______________ GROUP#______________

NO FAULT______________ CLAIM #______________ ADJUSTER______________

ADDRESS______________________ PHONE#______________________

-REFERRING OR PRIMARY DOCTOR____

I AUTHORIZE DR. VELICKOVIC TO FURNISH MY INSURANCE CARRIER WITH ALL INFORMATION TO PROCESS MY CLAIM FOR SERVICES RENDERED. IN REGARD TO MEDICARE I UNDERSTAND THAT REIMBUREMENT FOR SOME SERVICES, TESTS ETC. DEEMED NECESSARY BY MY PHYSICIAN AND EXPLAINED TO ME, MAY NOT BE COVERED UNDER MEDICARE AND DENIED FOR PAYMENT. I WILL BE RESPONSIBLE FOR SUCH CHARGES.

IN REGARD TO MANAGED CARE/REFERRAL PLANS I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO REQUEST REFERRAL FROM MY PRIMARY CARE DOCTOR IN ADVANCE AND TO BE AWARE OF THE AMOUNT OF ALLOWABLE VISITS PER REFERRAL.

I HEREBY ASSIGN, TRANSFER, AND SET OVER TO DR.VELICKOVIC SUFFICIENT MONIES AND/OR BENEFIT TO WHICH I MAY BE ENTITLED TO FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, AND OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE TO COVER COSTS OF THE CARE RENDERED TO MYSELF AND MY DEPENDENTS.

I HAVE READ AND AGREE TO THE ABOVE INFORMATION.

______________________________ ______________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

DR. MIODRAG VELICKOVIC
1940 COMMERCE STREET SUITE 107, YORKTOWN HEIGHTS, NY 10598
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Can the office of Dr. Velickovic contact you for appointment reminders or other health-related benefits and services that may be of interest to you?

YES______ or NO______

Can the office of Dr. Velickovic leave a medically related message on your answering machine?

YES______ or NO______

Can the Office of Dr. Velickovic disclose PHI (Private health information) to a family member or a friend?

YES______ or NO______

If yes, please provide us with names and Date of Birth.

____

____

____

____

IF YOU SUFFER FROM SEIZURE, CONVULSIVE DISORDER, EPILEPSY, FAINTING OR DIZZY SPELLS, OR ANY CONDITION WHICH CAUSES UNCONCIOUSNESS NYS LAW REQUIRES THAT YOU DO NOT DRIVE FOR 1 YEAR AFTER THE LAST EVENT.

________________________ ________________
SIGNATURE OF PATIENT **DATE**

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ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

SIGNATURE____

PRINT NAME____

DATE____

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Name, Address, and Telephone number:

To facilitate your neurological evaluation, we would like you to answer the following questions and bring this letter in with you at the time of your appointment. Please elaborate on any "YES" answers, using the reverse side of this page or the space on the last page if necessary.

Birth Date: / / Age: Sex:

Place of birth:

Purpose of consultation:

Are you followed by a general practitioner, internist or pediatrician?
If so, please give name, address and telephone:

Are you right-handed or left-handed:

Present height: Present weight:

1. Marital status: Spouse age: Spouse Health:

2. Educational level:

3. Are you presently employed?

Occupation Present:

Former:

How many children do you have (list names, sex, and ages)

4. Who currently lives with you at home?

Do you have any pets (list)?

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5. **Smoking History: (If You Never Smoked, Place 0 in All Answers.)**

year stopped: ________ **number of years smoked _______**

current number of packs/day:____ **maximum number of packs/day in the past: ____**

Drinking History: (IF YOU NEVER DRANK ALCOHOL, PLACE 0 IN ALL ANSWERS.)

Current status:	**The maximum drunk in past:**
number of beers/day:___	**number of beers/day:___**
glasses of wine/day:___	**glasses of wine/day:___**
ounces of hard alcohol/day:___	**ounces of hard alcohol/day:___**

Have you in past or do you use any recreational drugs (when, what and how much)?

1. **What medicines are you taking now? Please list them and their doses. (Include nasal sprays and vitamins.) (Use reverse side if necessary)**

List the medicines you have taken in the past for your present illness.

Have you ever been exposed to any toxic substances?

What other medications do you take on a regular basis (including over-the-counter drugs, vitamins, sleeping pills, antihistamines, cold remedies, and birth control pills)?

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2. Have you ever been hospitalized? If so, when, where, and for what?

3. What other medical problems do you have?

REVIEW OF SYSTEMS

Do you have any of the following? Please use the back of the page to elaborate when pertinent.

Allergies?

Are you allergic to any medications?

Fever
Weight loss
Visual changes
Hearing loss
Earache
Loss of consciousness
Ringing in your ears
Coughing or vomiting
Sore throat
Change in taste or smell
Swollen glands
Depression

Difficulty swallowing
Heart disease
Chest pain
Palpitations
Shortness of breath
Cough
Bronchitis
Asthma
Constipation
Diarrhea
Hot flushes

Black or tarry stools
Blood in stools
Problems with urination
Decrease sex drive
Impotence
Bone problems
Joint pain
Skin problem
Bleeding or bruising
Anemia

Headaches
Change in mental acuity/memory
Sleepiness/Sedation
Difficulty speaking
Dizziness or vertigo
Clumsiness or unsteadiness
Weakness
Numbness or tingling
Difficulty sleeping
Anxiety

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FAMILY HISTORY

1. **Father's Current Age (if alive): Or: Age of death: Cause of death:**

   Any medical problems:

   Mother's Current Age (if alive): Or: Age of death: Cause of death:

   Any medical problems:

   Do you have brothers or sisters? List ages, and health and death status.

   Please List health status of your children:

2. **Is there any disease that tends to run in your family (e.g. diabetes, high blood pressure, nervous or mental disease, or something like your present condition)?**

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Patient signature______________________________________**Date**__________________

Physician=s Statement: I have reviewed this document on this date

Physician Signature **Date**