Haodong Song, M.D.
Diplomate, The American Board of Psychiatry and Neurology (N)

2698 Highway 516 Ste D, Old Bridge, NJ 08857
Tel: (732) 707-3771 Fax: (732) 707-3772

Account Number:
Date:

Patient Information

Please answer all questions fully

Patient								
First Name	Last Name	MI	Social Security	Age	Date of Birth*	Sex*	Marital Status	Race*

Mailing Address	City	State	Zip code	Home Phone
Employer	**City**	**State**	**Zip code**	**Work Phone**

Preferred Language*	Ethnicity* ☐ Non-Hispanic ☐ Hispanic	E-mail Address*	Mobile Phone

Emergency Contact Information			
Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

Primary Doctor	**Referring Doctor**	**Referring Doctor Address**	**Phone**	**Fax**

Pharmacy	**Address**	**Phone**	**Fax**

Insurance Information				
Primary Insurance Company	Subscriber's Name, Date of Birth, SSN	Relationship	Policy # /Group #	Copay
Second Insurance Company	Subscriber's Name, Date of Birth, SSN	Relationship	Policy # /Group #	Copay
Third Insurance Company	Subscriber's Name, Date of Birth, SSN	Relationship	Policy # /Group #	Copay

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I acknowledge that interest or a fee, at the provider's current rate, may be charged on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

I acknowledge that I have received the HIPAA Notice of Privacy Practices.
Initial:_____

I acknowledge that I have read and agree to all office policies.
Initial:_____

I agree to receive text, voice and email appointment reminders with confirmation.
Initial:_____

Signature: _____ Date: _____
(Signature of insured or authorized person, patient or parent if minor)

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IN THE EVENT MY PHYSICIAN SHOULD NEED MY MEDICAL RECORDS FROM A HOSPITAL OR ANOTHER MEDICAL OFFICE, I HEREBY GIVE MY AUTHORIZATION TO HAVE THIS INFORMATION RELEASED TO:

HAODONG SONG, M.D.

NAME: (print) _____

D.O.B.: _____

SIGNATURE: _____

WITNESS: _____

DATE: _____

New Patient Form

Name: _____ Date: _____ Height*: _____ Weight*: _____ ☐ R ☐ L Handed

Complaint: What is the **main** reason(s) you are seeking a neurological evaluation: _____

_____

Approximate date of onset: _____ Other associated symptoms: _____

_____

Past Medical History: Please check yes or no.

	Yes	No		Yes	No		Yes	No
Asthma			Head injury			Bleeding tendency		
Emphysema			Heart disease			Stroke		
Cancer			High blood pressure			Thyroid disease		
Diabetes			High cholesterol			Lyme disease		

Other medical problems, prior surgeries and hospitalizations:

_____ _____

_____ _____

_____ _____

Social History: Occupation: _____ Level of education: _____

Living situation: _____

Alcohol: ☐ no ☐ currently ☐ past, but quit (how long ago) _____ , How much? _____

Smoking*: ☐ non-smoker ☐ previous smoker: _____ packs per day, quit _____(how long ago)

Currently smoke per day: ☐ few cigarettes ☐ up to 1 pack ☐ 1-2 packs ☐ 2 or __ packs

Recreational Drugs: ☐ no ☐ yes, _____

Family Medical History: List disease(s) and the family member(s) with the disease(s).

_____ _____

_____ _____

Review of Symptoms: Please check yes or no, describe or write down symptoms not listed in the blank rows.

	Yes	No		Yes	No
Recent weight change			Fatigue		
Fever			Joint pain /swelling		
Blurred vision			Weakness in muscles or joints		
Hearing loss			Muscle pain / cramps		
Ringing in the ears			Neck or low back pain		
Coughing			Rash		
Chest pain			Headache / migraine		
Palpitations			Lightheadedness or dizziness		
Shortness of breath			Numbness or tingling sensations		
Nausea / vomiting			Memory loss		
Diarrhea			Trouble walking / gait disturbance		
Constipation			Nervousness / anxiety		
Rectal bleeding or blood in stool			Depression / moodiness		
Frequent urination			Insomnia		
Blood in urine			Excessive thirst or urination		
Incontinence or dribbling			Heat or cold intolerance		
			Fall within the past year		
Other symptoms:					

Allergies*: _____

Current Medications*: Please list dose and frequency if possible.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

BP: _____ HR/P: _____

☐ Fax to referral