VOLUSIA NEUROLOGY
Jeffrey S. Corak, M.D.
760 S. Volusia Ave, Suite 400
Orange City, FL 32763
(386) 774-0220
www.volusianeurology.com

PATIENT INFORMATION SHEET

Date: _____ 20_____

Last Name: _____ Home Phone: (_____)_____

First Name: _____ Middle Initial: ____ Work Phone: (_____)_____

Address: _____ Cell Phone: (_____)_____

City: _____ State: ____ Zip:_____ DOB: _____ Age: _____

SSN: _____

If Patient Is A Minor, Parentõs Name: _____ Email: _____

Employer: _____ Phone: (_____)_____

Address: _____

Pharmacy Name: _____ Phone: (_____)_____

Referred By: _____ Family Doctor: _____

Allergies: _____

In Emergency Notify: _____ Relationship: _____

If Insured Party Is Not Patient (i.e., spouse, parent, employer, etc) Complete Information Below:

Name: _____ Relationship: _____

Address: _____ DOB: _____

Phone: (_____)_____

Please Complete This Form And The Attached Medical Questionnaires And Bring With You To The Office For Your Appointment On: _____ At _____

Please Bring Insurance Cards

Office Fees Are Due At The Time Of Service

We Must Have 24 Hours Notice If You Are Unable To Keep This Appointment Or A Fee Will Be Charged

At Volusia Neurology your well being is our primary concern. In order to permit us to offer you the best treatment possible please complete this form as accurately and completely as you can.

Name: _____ Age: _____ Right / Left Handed

Please describe the problem that brings you to us (including dates, other doctors seen, tests done and treatments tried):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you suffer from:

- ☐ Weakness
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Headaches
- ☐ Numb / Burning Feet
- ☐ Slurred Speech
- ☐ Vision Problems
- ☐ Tremor
- ☐ Seizures
- ☐ Snoring
- ☐ Bladder Problems
- ☐ Numbness / Tingling
- ☐ Leg Pain
- ☐ Arm / Hand Pain
- ☐ Facial Pain
- ☐ Memory Loss
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Poor Balance
- ☐ Loss of Consciousness
- ☐ Fall Asleep During the Day
- ☐ Depression / Anxiety

List your other medical problems (e.g., High Blood Pressure, Diabetes):

_____

_____

_____

_____

(please turn over)

Have you ever had cancer? What kind? _____

List any operations you have had, including dates:

_____

_____

_____

_____

List all medications you are currently taking, including dosages:

_____

_____

_____

_____

_____

_____

_____

_____

List any medications you are allergic to:

_____

_____

_____

_____

Do you smoke? If yes, how much:

Do you drink alcohol? If yes, how much:

Marital status:

Number and ages of children:

What type of work do you (or did you) do:

Are there others in your family with the same problem as you?

List any medical problems in your

mother: father:

siblings: children:

VOLUSIA NEUROLOGY
Jeffrey S. Corak, M.D.
760 S. Volusia Ave, Suite 400
Orange City, FL 32763
(386) 774-0220
www.volusianeurology.com

REVIEW OF SYSTEMS

Please check all that are present:

- Ĭ Weight Loss
- Ĭ Fever

- Ĭ Blurred Vision
- Ĭ Double Vision
- Ĭ Eye Pain

- Ĭ Decreased Hearing
- Ĭ Ringing in Ears
- Ĭ Sore Throat

- Ĭ Pain on Urination
- Ĭ Incontinence
- Ĭ Blood in Urine

- Ĭ Neck Pain
- Ĭ Back Pain
- Ĭ Muscle Cramps

- Ĭ Chest Pain
- Ĭ Palpitations

- Ĭ Shortness of Breath
- Ĭ Cough

- Ĭ Difficulty Swallowing
- Ĭ Nausea/Vomiting
- Ĭ Diarrhea
- Ĭ Constipation
- Ĭ Blood in Stool

- Ĭ Depression
- Ĭ Anxiety

- Ĭ Weakness
- Ĭ Numbness/Tingling
- Ĭ Headaches

VOLUSIA NEUROLOGY
Jeffrey S. Corak, M.D.
760 S. Volusia Ave, Suite 400
Orange City, FL 32763
(386) 774-0220
www.volusianeurology.com

Dear Patient,

You have an appointment scheduled with Dr. Jeffrey Corak. Attached are patient information forms to be completed and brought with you to your appointment. Please also bring all medications, pertinent medical records and prior test results, and referrals (if needed). Without a referral you will be responsible for payment. Co-payments will be due at the time of service.

Should you need to contact us, our office hours are Monday to Friday, 9 am to 5 pm.

You must contact your pharmacy for all prescription refills. For written narcotic prescriptions we require a one-week notice. Prescriptions will not be refilled under any circumstances outside of office hours. If you need to pick up prescriptions or other items please do so after 4 pm.

Messages left for the nurse will be returned within 24 hours.

For reasons of confidentiality test results cannot be given over the telephone, but will be discussed at your next appointment. You will be contacted for any significant abnormal results.

Should you need to cancel your appointment, please contact our office 24 hours in advance or you will be subject to a missed-appointment fee.

We make every effort to be on time but your appointment could be delayed. We ask for your understanding should this occur.

Please feel free to contact our office with any questions or concerns.

VOLUSIA NEUROLOGY
Jeffrey S. Corak, M.D.
760 S. Volusia Ave, Suite 400
Orange City, FL 32763
(386) 774-0220
www.volusianeurology.com

Acknowledgement of Privacy Practices

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent. We may refuse to treat you if you do not sign this Consent Form or sign this Consent Form and then revoke it.

I acknowledge and agree that my protected health information and medical record information may be disclosed to the following individuals:

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

I have read and understand the information in this consent.

Patient Name (print): _____

Patient Signature: _____ **Date:** _____

Witness: _____