DR Story Neurology, PLLC
280 Dobbs Ferry Road, Suite 206
White Plains, NY 10607

Initial Consultation Information Form

Name:

DOB:

Address:

Contact information:	**Check to indicate:**
Cell -	( ) You may leave private message on voice mail
Home -	( ) You may leave private message on voice mail
Email -	( ) You may correspond non-private information by email

Please list the name and relationship of anyone else we may speak with about your private health information:

Please list any doctors (with contact info) you would like to receive your consultation letter:

Please sign below to indicate that you have been supplied with a copy of the document titled: "The Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices"

Sign: _____ Date:_____

For Medicare only: I authorize Dr. Story to disclose information to Medicare for the purposes of billing for services rendered. I authorize Medicare to release payment directly to DR Story Neurology, PLLC for said services.

Sign: _____ Date:_____

Initial Consultation Health Information Form

Why are you seeing Dr. Story?

What other medical problems do you have?

What medications are you taking?

Do you have any allergies to medications?

Do you have any habits that impact your health? (Smoking, excessive alcohol consumption, drug use)

Please bring any prior records, documents, imaging reports, and CD's with images that you would like reviewed during your visit.