The Nerve and Muscle Center of Texas

DEMOGRAPHIC INFORMATION FORM

(Please Print Clearly)

Today's Date:	PCP:

PATIENT INFORMATION

PATIENT'S LAST NAME:	FIRST:	MI:	BIRTH DATE:	SEX:	SOCIAL SECURITY NO.:

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE:	CELL PHONE:	EMAIL ADDRESS	MARITAL STATUS:
			Select...

SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	SPOUSE'S CELL PHONE

PATIENTS EMPLOYER	SPOUSE'S EMPLOYER

PATIENTS BUSINESS ADDRESS	SPOUSE'S BUSINESS ADDRESS

CITY, STATE, AND ZIP	CITY, STATE, AND ZIP

PATIENTS BUSINESS PHONE	SPOUSE'S BUSINESS PHONE

WHO REFERRED YOU TO OUR CENTER (PLEASE CHECK ONE BOX):	☐ DR.	DR'S PHONE
DR'S ADDRESS:		☐ INTERNET

☐ FAMILY	☐ FRIEND	☐ CLOSE TO HOME/WORK	☐ HOSPITAL	☐ OTHER

OTHER FAMILY MEMBERS SEEN HERE:

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING AT SAME ADDRESS):	RELATIONSHIP TO PATIENT:	HOME PHONE NO.:	WORK PHONE NO.:

ADDRESS	CITY	STATE	ZIP

Assignment of Benefits: I hereby consent to treatment. I hereby irrevocably assign and transfer to Houston Neurocare, PA any monies or benefits to which I may be entitled, including benefits/monies from governmental payers such as Medicare, my insurance company, HMO, or other third parties who are financially responsible for my medical care. I authorize and direct Houston Neurocare, PA, having treated me, to release to such payers or other third parties who are financially responsible for my medical care, all information needed (including but not limited to medical records, copies of claims and itemized bills) to substantiate payment for my medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I also appoint Houston Neurocare, PA as my authorized representative to pursue all rights of payment, to ascertain the benefits available, to collect benefits directly from my insurance company and to appeal denials and proceed against my insurance company in any action, including legal suit, on my behalf if for any reason my insurance company refuses to pay my claim. The appointment shall include all rights to recover attorney's fees and costs for such action brought by Houston Neurocare, PA as my assignee. I further agree to provide information as necessary and to cooperate with Houston Neurocare, PA to process and obtain payments.

Patient/Guardian signature *Date*

HOUSTON NEUROCARE, P.A.
NERVE AND MUSCLE CENTER OF TEXAS
AZIZ SHAIBANI, M.D.

PRIVACY PRACTICES ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have been given an opportunity to request or review a copy of our *Notice of Privacy Practices (***https://www.nerveandmuscle.org/privacy-practices***)* which describes how medical information about you may be used and disclosed and how you can get access to that information.

If you have any specific restrictions you would like to place on the use and/or disclosure of your information, please list below:

_____
_____
_____
_____
_____

Patient Name: _____
(Please Sign Name)

Patient Date of Birth: _____

August 2025

Authorization For The Use And/Or Disclosure Of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization (please check all that apply):

   - ☐ DISCHARGE SUMMARIES
   - ☐ PROGRESS NOTES
   - ☐ MEDICATIONS
   - ☐ HISTORY AND PHYSICAL EXAMS
   - ☐ LAB REPORTS

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

(TEL):	(FAX):

3. I authorize the following persons (or class of persons) to receive my protected health information:
   AZIZ SHAIBANI, MD, FACP, FAAN
   NERVE AND MUSCLE CENTER OF TEXAS
   (TEL) 713-795-0033 (FAX) 877-935-8122

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires _____

7. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Houston Neurocare, P.A., nor will it affect my eligibility benefits.

9. My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):

_____

DOB: _____

I certify I have received a copy of the authorization.

_____ _____
SIGNATURE DATE

_____ _____
PRINT NAME RELATIONSHIP TO PATIENT

OR

_____
NAME OF PERSONAL REPRESENTATIVE

PATIENT HISTORY

NAME _____DATE_____

OCCUPATION_____

RACE_____ PRIMARY LANGUAGE_____

HEIGHT _____ Ft _____ In WEIGHT_____

PRESENT COMPLAINTS HOW LONG THEY HAVE BEEN PRESENT:

_____ _____

_____ _____

_____ _____

PAST HISTORY - PLEASE LIST ANY MAJOR ILLNESSES: (use last page if space is not enough)

_____

CURRENT MEDICATIONS WITH STRENGTH AND DOSE: (use last page if space is not enough)

1._____ 2._____

3._____ 4._____

5._____ 6._____

PLEASE LIST DRUG/FOOD/ENVIRONMENTAL ALLERGIES:

DO YOU HAVE OR HAVE YOU HAD (Check the right boxes) ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ STROKE

☐ CANCER ☐ NEUROPATHY

PAST SURGERIES (INCLUDING NECK OR BACK SURGERY):

HAVE YOU EVER HAD A CAT SCAN, MRI OR MYELOGRAM? IF YES, LIST DATE AND LOCATION:

DO YOU SMOKE: (PLEASE CIRCLE ONE) YES ☐ NO ☐ IF YES, HOW MANY PACKS/DAY_____

DO YOU DRINK ALCOHOL (PLEASE CIRCLE ONE) YES ☐ NO ☐ IF YES, HOW MANY DRINKS PER WEEK

NUMBER OF CHILDREN MALE_____FEMALE_____

PATIENT'S NAME _____

HAVE ANY OF YOUR *CHILDREN* SUFFERED A NEUROLOGICAL ILLNESS (PLEASE CIRCLE ONE) ◯ YES ◯ NO

IF YES, PLEASE EXPLAIN_____

NUMBER OF SIBLINGS: Brothers _____Sisters _____

DO ANY OF YOUR *FAMILY* MEMBERS HAVE:

HIGH ARCHED FEET (PLEASE CIRCLE ONE) ☐ YES OR NO ☐
FLAT FEET (PLEASE CIRCLE ONE) ☐ YES OR NO ☐
EXERCISE INTOLERANCE (PLEASE CIRCLE ONE) ☐ YES OR NO ☐
TROUBLE WALKING (PLEASE CIRCLE ONE) ☐ YES OR NO ☐
MUSCLE DISEASE (PLEASE CIRCLE ONE) ☐ YES OR NO ☐
DIABETES (PLEASE CIRCLE ONE) ☐ YES OR NO ☐
NEUROPATHY (PLEASE CIRCLE ONE) ☐ YES OR NO ☐

OTHER (PLEASE SPECIFY OTHER DISORDERS)

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS/COMPLAINTS?

	YES	NO	DESCRIBE IF NEEDED
POOR COORDINATION	☐	☐	_____
MUSCLE CRAMPS	☐	☐	_____
MUSCLE WEAKNESS	☐	☐	_____
LOSS OF CONTROL OF ARMS OR LEGS	☐	☐	_____
LOSS OF MUSCLE BULK	☐	☐	_____
MUSCLE PAIN	☐	☐	_____
EXERCISE INDUCED MUSCLE CRAMPS	☐	☐	_____
CHANGE IN URINE COLOR AFTER EXCERCISE	☐	☐	_____
DIFFICULTY CLIMBING STAIRS	☐	☐	_____
DIFFICULTY RISING FROM DEEP CHAIR	☐	☐	_____
BLURRED VISION	☐	☐	_____
DOUBLE VISION	☐	☐	_____
DROOPY EYELIDS	☐	☐	_____
PAIN BEHINE THE EYES	☐	☐	_____
FATIGABILITY OF JAW MUSCLES	☐	☐	_____
HOARSENESS	☐	☐	_____
GENERALIZED FATIGUE	☐	☐	_____
SLURRED SPEECH	☐	☐	_____
DIFFICULTY SWALLOWING	☐	☐	_____
SHORTNESS OF BREATH	☐	☐	_____
CONVULSIONS	☐	☐	_____
NUMBNESS	☐	☐	_____
TINGLING	☐	☐	_____
NECK PAIN	☐	☐	_____
BACK PAIN	☐	☐	_____
ARM PAIN	☐	☐	_____

PATIENT'S NAME _____

LEG PAIN	☐	☐	_____
FEET PAIN	☐	☐	_____
SHOULDER PAIN	☐	☐	_____
STIFFNESS	☐	☐	_____
HEARING LOSS	☐	☐	_____
APETITE CHANGES	☐	☐	_____
WEIGHT LOSS	☐	☐	_____
INSOMINA	☐	☐	_____
ANXIETY	☐	☐	_____
DEPRESSION	☐	☐	_____
COUGH	☐	☐	_____
FEVER	☐	☐	_____
CHILLS	☐	☐	_____
NIGHT SWEATS	☐	☐	_____
PROFUSE SWEATING	☐	☐	_____
WHEEZING	☐	☐	_____
CHEST TIGHTNESS	☐	☐	_____
PALPITATIONS	☐	☐	_____
CHEST PAIN	☐	☐	_____
URINARY FREQUENCY	☐	☐	_____
POOR CONTROL OF BLADDER	☐	☐	_____
CONSTIPATION	☐	☐	_____
DIARRHEA	☐	☐	_____
NAUSEA	☐	☐	_____
VOMITING	☐	☐	_____
SKIN RASH	☐	☐	_____
DIZZINESS	☐	☐	_____

Falls

- ☐ No falls in the past year
- ☐ One fall with injury in the past year
- ☐ Two or more falls with injury in the past year
- ☐ One fall without injury in the past year
- ☐ Two or more falls without injury in the past year

Feeling down, depressed or hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day
- ☐ Decline to specify

Depression - Over the past 2 weeks, how often have you been bothered by any of the following problems:

- ☐ Little interest or pleasure in doing things?
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day
- ☐ Decline to specify

DO YOU HAVE AN ADVANCED MEDICAL DIRECTIVE? YES ☐ NO ☐

I agree this information is correct

_____

Patient's signature