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

| Account Number:<br>Date:  |                             |   | Pl                    |       | ient Intans |          |              |            |                          |        |         |               |        |                  |
|---|-----------------------------|---|-----------------------|-------|-------------|----------|--------------|------------|--------------------------|--------|---------|---------------|--------|------------------|
| Patient   |                             |   |                       |       |             |          |              |            |                          |        |         |               |        |                  |
| First Name  | Last Name                   |   | MI                    | Soc   | cial Securi | ity      | Age          | Date of    | Birth*                   | Sex*   | Ma      | arital Status | Rac    | e*               |
| Mailing Address   |                             |   |                       |       | City        |          |              | State      | Zip c                    | ode    | Н       | Iome Phone    | e      |                  |
| Employer  |                             |   |                       |       | City        |          |              | State      | Zip c                    | ode    | W       | Vork Phone    | ;      |                  |
| Preferred Language*   | Ethnicity  Non-H  Hispan    | lispanic  | E-mail A              | Addre | ess*        |          |              |            |                          |        | M       | Iobile Phoi   | ne     |                  |
| Emergency Contact I   | nformation                  | 1   |                       |       |             |          |              |            |                          |        |         |               |        |                  |
| Contact Name  | mioi matioi                 | 1   | Relation              | ship  | Pri         | mary P   | hone l       | Number     |                          |        | Seco    | ndary Phor    | ne Nu  | mber             |
|   | 1 .                         |   |                       |       |             |          |              |            |                          |        |         |               |        |                  |
| Primary Doctor  | Referri                     | ing Doctor                                      | r                     | Re    | ferring l   | Doctor   | Add          | ress       |                          | Phone  | 2       |               | Fax    | <b>(</b>         |
|   |                             | 1   |                       |       |             |          |              |            |                          |        |         |               |        |                  |
| Pharmacy  |                             | Address   | <b>S</b>              |       |             |          |              |            |                          | Phone  | e       |               | Fax    | <u> </u>         |
|   |                             | ı   |                       |       |             |          |              |            |                          |        |         |               |        |                  |
| Primary Insurance Compa   |                             | Subscriber                                      | 's Name,              | Date  | of Birth, S | SSN      | F            | Relationsh | ip                       | Policy | / # /Gr | roup #        |        | Copay            |
| Second Insurance Company  |                             | Subscriber's Name, Date of Birth, SSN Rela      |                       |       |             |          |              | Relationsh | elationship Policy # /Gr |        |         | roup #        |        | Copay            |
| Third Insurance Company   |                             | Subscriber's Name, Date of Birth, SSN Relations |                       |       |             |          |              | Relationsh | ip                       | Policy | / # /Gr | roup #        |        | Copay            |
| Patient Release: I certify the informatio claims to insurance corpayment of medical be balances owing to the part of the part | npanies or<br>nefits to the | their agend<br>provider.                        | cies (incl<br>I ackno | ıding | g Medicai   | re), for | purp         | ose of fil | ling an                  | d pay  | ment    | of medica     | ıl cla | ims. I authorize |
| I permit a copy of this   | release to b                | e used in p                                     | place of the          | ne or | riginal.    |          |              |            |                          |        |         |               |        |                  |
| I acknowledge that I had Initial:   | ave received                | d the HIPA                                      | A Notic               | e of  | Privacy 1   | Practic  | es.          |            |                          |        |         |               |        |                  |
| I acknowledge that I ha   | ave read and                | d agree to                                      | all office            | poli  | cies.       |          |              |            |                          |        |         |               |        |                  |
| I agree to receive text,<br>Initial:  | voice and e                 | email appoi                                     | intment r             | emin  | nders with  | h confi  | rmati        | on.        |                          |        |         |               |        |                  |
| Signature:(Signature o  | f insured or                | authorize                                       | d person.             | patie | ent or par  | rent if  | _ Da<br>mino | te:<br>r)  |                          |        |         |               | -      |                  |

## HAODONG SONG, M.D.

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

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**

| 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 Fall within the past year   | Name:                     |              | Da               | ate:       |         | _ Height*: _    |                   | Weight*:                                     | $\square$ R $\square$ L $\square$ | Hande   |  |
|--|---------------------------|--------------|------------------|------------|---------|-----------------|-------------------|--|-----------------------------------|---------|--|
| Past Medical History: Please check yes or no.  Yes No  | <b>Complaint:</b> What is | the main 1   | reason(s) you    | ı are seek | ing a   | neurological    | evaluat           | ion:   |                                   |         |  |
| Yes   No   | Approximate date of       | onset:       |                  | Other      | asso    | ciated sympton  | ms:               |  |                                   |         |  |
| Yes   No   | Doct Modical Histor       | vu Dlagge    | ah a ale voa a a |            |         |                 |                   |  |                                   |         |  |
| Asthma   Head injury   Bleeding tendency   Emphysema   Heart disease   Stroke   Cancer   High blood pressure   Thyroid disease   Diabetes   High cholesterol   Lyme disease   Diabetes   High cholesterol   Lyme disease   Diabetes   Diabetes   Lyme disease   Diabetes   Diabetes   Lyme disease   Diabetes    | rast Medical Histor       |              |                  | по.        |         | Vec             | No                | 1  | Vec                               | No      |  |
| Emphysema  | Δ sthma                   | 105 100      |                  | V          |         | 1 CS            | 110               | Bleeding tendency                            |                                   | INU     |  |
| Cancer   High blood pressure   Thyroid disease   Diabetes   High cholesterol   Lyme disease    Other medical problems, prior surgeries and hospitalizations:    Social History: Occupation:  |                           |              |                  |            |         |                 |                   |  |                                   |         |  |
| Diabetes   High cholesterol   Lyme disease   |                           |              |                  |            |         |                 |                   |  |                                   |         |  |
| Other medical problems, prior surgeries and hospitalizations:    Social History: Occupation:   |                           |              |                  |            |         |                 | 1                 |  |                                   |         |  |
| Living situation:  Alcohol:  | Other medical prob        | lems, prio   | r surgeries      | and hosp   | itali   | zations:        | •                 |  | <u>'</u>                          | •       |  |
| Living situation:  Alcohol:  | Social History: Occ       | upation: _   |                  |            |         | Level o         | of educa          | ation:                                       |                                   |         |  |
| Alcohol:   | T inside a distribution . |              |                  |            |         |                 |                   |  |                                   |         |  |
| Smoking*:    non-smoker   previous smoker:   packs per day, quit   (how long ago)  | Alcohol: □ no □ o         | currently    | ☐ past, but c    | quit (how  | long    | ago)            | _ , Hov           | w much?                                      |                                   |         |  |
| Recreational Drugs:  no yes,   | Smoking*: □ non-          | smoker       | ☐ previou        | s smoker:  | :_      | packs per       | day, qı           | uit (how                                     | long ago)                         |         |  |
| Recreational Drugs:  no yes,   | Curren                    | tly smoke    | per day: ☐ f     | few cigare | ettes   | up to 1 page    | ck 🗍              | $1-\overline{2 \text{ packs } \square}$ 2 or | packs                             |         |  |
| Review of Symptoms: Please check yes or no, describe or write down symptoms not listed in the blank rows.    Yes   | Recreational Drugs:       | _ no □       | Î yes,           | 2          |         |                 |                   | *  |                                   |         |  |
| 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 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 Fall within the past year  |                           |              |                  |            |         |                 | the di            | sease(s).                                    |                                   |         |  |
| Yes       No       Yes       No         Recent weight change       Fatigue       Fatigue         Fever       Joint pain /swelling       Blurred vision         Hearing loss       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   | Tunning Tyrodical IIIS    | cor y · List | ansease(s) an    | ia the lan | 1115 11 |                 | 1 1110 111        | .sease(s).                                   |                                   |         |  |
| Yes       No       Yes       No         Recent weight change       Fatigue       Fatigue         Fever       Joint pain /swelling       Blurred vision         Hearing loss       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   |                           |              |                  |            |         | -               |                   |  |                                   |         |  |
| Yes   No   Yes   No     Yes   No   |                           |              |                  |            |         | · -             |                   |  |                                   |         |  |
| Recent weight change Fatigue Joint pain /swelling Blurred vision Weakness in muscles or joints Muscle pain / cramps Nuscle pain / cramps Neck or low back pain Rash Lightheadedness or dizziness Shortness of breath Numbness or tingling sensations Diarrhea Trouble walking / gait disturbance Constipation Rectal bleeding or blood in stool Frequent urination Blood in urine Excessive thirst or urination Insontnia Eatle walking / Fall within the past year  | <b>Review of Symptom</b>  | s: Please    | check yes or     | no, descri | ibe o   | r write down s  | ymptoi            | ms not listed in the                         | blank rows.                       |         |  |
| 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 Fall within the past year  |                           |              |                  | Yes N      | lo      |                 |                   |  | Yes                               | No      |  |
| 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 Fall within the past year   | Recent weight change      |              |                  |            |         | Fatigue         |                   |  |                                   |         |  |
| Hearing loss Ringing in the ears Roughing Rash Chest pain Palpitations Palpitations Numbness or tingling sensations Nausea / vomiting Memory loss Diarrhea Constipation Rectal bleeding or blood in stool Blood in urine Rectal bleeding Incontinence or dribbling Muscle pain / cramps Neck or low back pain Rash Lightheadedness or dizziness Numbness or tingling sensations Numbness or tingling sensations Nemory loss Diarrhea Trouble walking / gait disturbance Nervousness / anxiety Rectal bleeding or blood in stool Depression / moodiness Insomnia Blood in urine Excessive thirst or urination Heat or cold intolerance Fall within the past year  | Fever                     |              |                  |            |         | Joint pain /sw  | nt pain /swelling |  |                                   |         |  |
| Ringing in the ears  Coughing  Rash  Chest pain  Palpitations  Shortness of breath  Numbness or tingling sensations  Nausea / vomiting  Diarrhea  Constipation  Rectal bleeding or blood in stool  Frequent urination  Blood in urine  Incontinence or dribbling  Neck or low back pain  Rash  Numbness pain  Headache / migraine  Lightheadedness or dizziness  Numbness or tingling sensations  Memory loss  Trouble walking / gait disturbance  Nervousness / anxiety  Depression / moodiness  Insomnia  Excessive thirst or urination  Heat or cold intolerance  Fall within the past year   | Blurred vision            |              |                  |            |         | Weakness in 1   | nuscles           | or joints                                    |                                   |         |  |
| Coughing Chest pain Ch | Hearing loss              |              |                  |            |         | Muscle pain /   | cramps            | -  |                                   |         |  |
| 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   | <u>-</u>                  |              |                  |            |         |                 |                   |  |                                   |         |  |
| Palpitations  Lightheadedness or dizziness  Numbness or tingling sensations  Nausea / vomiting  Memory loss  Diarrhea  Trouble walking / gait disturbance  Constipation  Nervousness / anxiety  Rectal bleeding or blood in stool  Frequent urination  Blood in urine  Excessive thirst or urination  Incontinence or dribbling  Heat or cold intolerance  Fall within the past year   | Coughing                  |              |                  |            |         | Rash            | -                 |  |                                   |         |  |
| 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  |                           |              |                  |            |         | Headache / m    | igraine           |  |                                   |         |  |
| Shortness of breath  Numbness or tingling sensations  Nausea / vomiting  Diarrhea  Trouble walking / gait disturbance  Constipation  Nervousness / anxiety  Rectal bleeding or blood in stool  Frequent urination  Blood in urine  Excessive thirst or urination  Incontinence or dribbling  Heat or cold intolerance  Fall within the past year   | •                         |              |                  |            |         |                 |                   | izziness                                     |                                   |         |  |
| 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  |                           |              |                  |            |         |                 |                   |  |                                   |         |  |
| 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  |                           |              |                  |            |         |                 |                   | ,  |                                   |         |  |
| 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  |                           |              |                  |            |         |                 | ng / gai          | it disturbance                               |                                   |         |  |
| Frequent urination Insomnia  Blood in urine Excessive thirst or urination Incontinence or dribbling Heat or cold intolerance Fall within the past year   | Constipation              |              |                  |            |         |                 |                   |  |                                   |         |  |
| Blood in urine Excessive thirst or urination Incontinence or dribbling Heat or cold intolerance Fall within the past year  | Rectal bleeding or blood  | d in stool   |                  |            |         | Depression / 1  | noodine           | ess  |                                   |         |  |
| Incontinence or dribbling Heat or cold intolerance Fall within the past year   | Frequent urination        |              |                  |            |         | Insomnia        |                   |  |                                   |         |  |
| Fall within the past year  | Blood in urine            |              |                  |            |         | Excessive thir  | st or ur          | ination                                      |                                   |         |  |
|  | Incontinence or dribblin  | ng           |                  |            |         | Heat or cold i  | ntolerar          | ice  |                                   |         |  |
| Other symptoms:  |                           |              |                  |            |         | Fall within the | e past y          | ear  |                                   |         |  |
|  | Other symptoms:           |              |                  |            |         |                 |                   |  |                                   |         |  |
|  |                           |              |                  |            |         |                 |                   |  |                                   |         |  |
|  | Allorgios*:               |              |                  |            |         |                 |                   |  |                                   |         |  |
| Allorgios*.  |                           | «*. Dl       | 1:-4             | 1 €        | :c      |                 |                   |  |                                   |         |  |
| Allergies*:  | Current Medication        | s": Please   | list dose and    | i frequenc | cy 11   | possible.       |                   |  |                                   |         |  |
|  |                           |              |                  |            |         |                 |                   |  |                                   |         |  |
| Allergies*:  |                           |              |                  |            |         |                 |                   |  |                                   |         |  |
|  |                           |              |                  |            |         |                 |                   |  |                                   |         |  |
|  |                           |              |                  |            |         | <u> </u>        |                   |  | ·                                 |         |  |
|  |                           |              |                  |            |         |                 |                   |  |                                   |         |  |
|  |                           |              |                  |            |         | · ·             |                   |  |                                   |         |  |
|  |                           |              |                  |            |         |                 | ВP                | :  | HR/P:                             |         |  |
|  |                           |              |                  |            |         |                 | 21                | •  | ☐ Fax t                           | o refer |  |