Neurology, Sleep & Pulmonary Specialists

Rajiv B. Nanavaty, M.D.
Rajnish Dhawan, M.D.
Lacey D. Lyle, F.N.P.
Emily Massaro, F.N.P.
Ashley Foreman, D.N.P.

MEDICAL INFORMATION - NEUROLOGY

Patient's Name: ______________________________ Date of Birth: ____________________
First Middle Last Suffix

Family Doctor: ____

Referring Doctor (if different from Family/Primary Care Doctor): ______________________

Reason for Today's Visit (Chief Complaint)::_____________________________________

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Current Medical Problems: ____

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Prior Surgeries: ____

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Allergies: ____

Please list all current medications (or provide us with a current Medication List – we will make a copy for our records.) Please use the back of this page if you need additional room.

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I hereby authorize treatment by the Providers of Neurology & Sleep Associates of Suffolk.

_______________________________________ ____________________
Patient/Guardian Signature Date

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