Eric C. Drew, MD

MD Neurology

4931 Long Prairie Road, Ste 100 Flower Mound, TX 75028
Phone: 972-219-5397 Fax: 972-219-5609

New Patient Intake

Patient Name:_____ **Phone Number:**_____

Address:_____ **City/State/Zip:**_____

Date of Birth:____/____/____ **Social Security:**____/____/____

How did you hear about us?_____

CHIEF COMPLAINT: What is the main symptom that caused you to make this appointment today?

HISTORY OF PRESENT ILLNESS: Please describe when and how your symptoms began and how they've progressed.

PAST MEDICAL HISTORY: Please list any previous or current illnesses and treatments with approx.. dates.

☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ Heart disease ☐ High Cholesterol

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CURRENT MEDICATIONS: Use back of this sheet if additional space is needed.

Medication Name	Dosage (mg)	How many times per day do you take?

MEDICATION ALLERGIES:

Medication/Substance	Reactions (e.g. rash, hives, wheezing)

SURGICAL, PREGNANCY, AND INJURIES: Please provide description and approximate date.

Surgeries/Injuries _____

_____

_____

_____

Pregnancies _____

FAMILY HISTORY: Please list any illnesses in your family members especially those that are relevant to your current problems. _____

_____

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SOCIAL HISTORY:

Marital Status:_____

How much do you weigh?_____

Occupation:_____

What is your height?_____

Have you been exposed to HIV?

○ Yes ○ No

Do you smoke cigarettes?

○ Yes - # packet per day? _____

○ Quit ○ Never

Do you drink alcohol?

○ Yes - Daily? Yes ○ No ○

○ Quit ○ Never

HAVE YOU HAD ANY OF THESE TESTS?

Test	When?	Where?
☐ MRI brain		
☐ MRI spine		
☐ CT head		
☐ CT spine		
☐ EEG		
☐ EMG		
☐ Carotid Artery		
☐ Echocardiogram		
☐ Lumbar Puncture (Spinal Tap)		

ANYTHING ELSE YOU WOULD LIKE TO TELL THE DOCTOR?

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Billing Information

Patient Name:_____

Date of Birth:_____ Social Security:_____

Street Address: _____

City, State, Zip: _____

Primary Contact Number:_____ (cell, home or work)

Secondary Contact Number:_____ (cell home or work)

Email:_____ (for appointment reminders, emails are never sold or distributed)

Emergency Contact:_____

Relation to Patient:_____ Phone Number: _____

How did you hear about us? _____

Primary Care Physician:_____

Office Phone:_____ Fax:_____

Referring Physician:_____

Office Phone:_____ Fax:_____

Pharmacy Name:_____

Pharmacy Address:_____ City:_____

State, Zip:_____ Phone:_____ Fax:_____

Check one of the following:

◯ Self Pay ◯ Insurance Coverage? (Please fill out the below information)

Insurance Company:_____

Member ID:_____ Group ID: _____

Primary Policy Holder Name: _____ DOB:_____

Relation to Patient:_____

Address (if different from patient) _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ Phone _____ Fax _____
to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request & authorization applies to:

◯ All healthcare information

◯ Healthcare information relating to the following treatment, condition or dates: _____

_____

◯ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

◯Yes ◯No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

◯Yes ◯No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

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MD NEUROLOGY

Patient Consent/Financial Policy

WORKERS COMPENSATION & MOTOR VEHICLE ACCIDENTS

Please be aware MD Neurology/Drew Neurology does not see cases related to Workers Compensation or Motor Vehicle Accidents. We are happy to refer you to another neurologist in the area.

FINANCIAL POLICY

We require payment in full for any amounts designated to be the patient's responsibility at the time services are rendered. This may include co-pays, co-insurance, and/or deductible amounts. If the amount collected at the time of service results in an overpaid claim, a refund will be processed within 30 days once all claims are settled and there is no payment due on any other claim or date of service.

INSURANCE COVERAGE

Please inform the receptionist of any type of insurance coverage you may have. You are responsible for knowing the specific rules of your insurance carrier. We are contracted (in-network) with several insurance carriers however, if we are not contracted with your insurance carrier, you may be required to pay a higher fee than if you were seen by a contracted (in-network) provider. It is your responsibility to pay any co-pay, co-insurance, deductible, or other non-covered amounts not paid by your insurance carrier at the time of service. Failure to present your current insurance information prior to services being rendered may result in denial of your claim and subsequent billing for unpaid services. Even though we are happy to assist you in receiving reimbursement from your insurance carrier, please understand that you, the patient, ultimately have the final responsibility for your bill.

MANAGED CARE REFERRAL PROCESS

Your plan may require a referral from you PCP to be on file with them before seeing a specialist. If a referral is required, it is your responsibility to work with your primary care physician to obtain this referral prior to your appointment. If MD Neurology/Drew Neurology is unable to verify your carrier has a referral on file, your appointment will be rescheduled or if you are seen without a valid referral, all charges will be the responsibility of you (the patient) or your legal guardian.

PAYMENT OF POST VISIT BALANCES

All post visit balances must be paid within 30 days of when the balance becomes the patient's responsibility and a statement from MD Neurology/Drew Neurology is received. An acceptable payment arrangement may be made in order to prevent outside collection activity. If your account becomes past due and we have to refer your account to a collection agency, a $35 collection agency fee will be added to your outstanding balance.

If you have any questions regarding your statement or outstanding balance you may contact our billing specialist at (972-221-6438)

COMPLETION OF OUTSIDE PAPERWORK

MD Neurology/Drew Neurology will charge a Processing Fee of $15.00 (+) $5.00 per page to complete Outside Paperwork. This includes Disability Forms and FMLA Paperwork. Payment is required in advance and paperwork will not be processed until payment is received. Please allow one week for paperwork to be completed.

AUTHORIZATION OF CARE

I grant permission for MD Neurology/Drew Neurology to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures.

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have be given or offered the MD Neurology/Drew Neurology HIPAA Notices of Privacy Practices.

Patient Name: _____

_____

Signature of Patient or Representative Relationship to Patient Date

*If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the Patient.

Revision 11/30/2017

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Patient Name:_____

Review of Systems: Please check any items that you are experiencing or have experienced recently.

General
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Loss of Appetite
- ☐ Fatigue/Tiredness
- ☐ Weight Gain/Loss
- ☐ Nervous/Anxious
- ☐ Depression
- ☐ Sleep Disturbance

Eyes
- ☐ Blurring
- ☐ Double Vision
- ☐ Vision Loss
- ☐ Eye Pain
- ☐ Sensitivity to Light

Ear/Nose/Throat
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Decreased Hearing
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Difficulty Tasting
- ☐ Difficulty with Smell

Genitourinary
- ☐ Incontinence
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urinary Frequency
- ☐ Male – Erectile Dysfunction
- ☐ Female – Heavy periods
- ☐ Female – No periods

Heart/Lungs
- ☐ Chest Pain
- ☐ Chest Pressure
- ☐ Heart Palpitations
- ☐ Shortness of Breath
- ☐ Leg Swelling
- ☐ Cough
- ☐ Wheezing

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in Bowel Habits
- ☐ Heartburn
- ☐ Choking spells
- ☐ Gas/Bloating
- ☐ Rectal Bleeding

Neck/Head
- ☐ Headaches
- ☐ Swollen Neck/Glands
- ☐ Stiff/Tender Neck
- ☐ Dentures/Partials

Psychiatric
- ☐ Suicidal Thoughts
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Stress

Extremities
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Stiffness
- ☐ Arthritis
- ☐ Rash
- ☐ Itching
- ☐ Dry Skin

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Neurological

- ☐ Paralysis
- ☐ Weakness
- ☐ Tingling
- ☐ Numbness
- ☐ Seizures
- ☐ Fainting
- ☐ Tremors
- ☐ Vertigo
- ☐ Memory Problems
- ☐ Poor Concentration
- ☐ Speech Problems
- ☐ Clumsiness
- ☐ Shuffling Gait
- ☐ Poor Balance

Other

- ☐ Heat/Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Abnormal Bruising
- ☐ Prolonged Bleeding
- ☐ Hives
- ☐ Recurrent Infections

HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

I understand that it is the policy of MD Neurology/Drew Neurology to restrict access to my Protected Health Information in accordance with federal law. The following may have access to my healthcare information:

1) The caregiver(s) providing health services

2) My insurance company(-ies) for payment of my claim

3) The person(s) indicated below:

Name(s) (Please Print)	**DOB**	**Information Access Preferences**
1. **Myself** (patient or legal guardian[1])	N/A	
2.		**Clinical Information**(please check one) ◯All or ◯Restricted*
3.		◯All or ◯Restricted*
4.		◯All or ◯Restricted*
5.		◯All or ◯Restricted*

*If you circle **Restricted** above, please specify what clinical information you do **NOT** wish to share with the person(s) in the above boxes:

- ☐ Sexually Transmitted Disease(s)
- ☐ Pregnancy
- ☐ Terminal Illness
- ☐ Mental/Behavioral Health
- ☐ Other _____

Communication preferences:

- ◯ I give consent for you to leave confidential clinical information on my answering machine
- ◯ I do **not** give consent for you to leave confidential clinical information on my answering machine

_____

Patient Signature Date Witness Signature

_____

Printed Patient Name Printed Witness Name

[1]Sate law permits both parents to have access to PHI unless we are provided a court order restricting this right