MD Neurology Health Questionnaire

Date _____
DOB _____

Name _____
Family Doctor _____

What is the reason for the consultation? _____

_____

When did these symptoms start? _____

Medical History: *Please mention all other previous or current medical problems.*

☐ Diabetes Type? 1☐ 2☐ (*since year:*)
☐ High Cholesterol: (*since year:*)
☐ Cancer Type:
☐ Head injury
☐ Psychiatric Illness
☐ Dialysis
☐ Thyroid Disorder
☐ Seizure
☐ Chronic Kidney Disease
☐ High Blood Pressure (*since year*)
☐ Coronary Artery Disease (*since year*)
☐ Heart Disease ☐ Stroke ☐ Sleep Apnea
☐ COPD
☐ Colon
☐ Other Illnesses (Please list): _____

Do you have a pacemaker?☐ defibrillator?☐ Are you on a blood thinner?☐

Surgical History: *Please mention all previous surgeries and the year.*

☐ Appendectomy
☐ Hysterectomy
☐ Cholecystectomy
☐ Coronary Bypass
☐ Orthopedic
☐ Spine
☐ Hernia
☐ Thyroid
☐ Hip/Knee Replacement
☐ Others: (please list) _____

Drug Allergies:	**Most Recent MRI:**
Occupation(before retirement):	**Educational Level:**
Married☐ Unmarried☐ Divorced☐	**No. of Children:** **Last Chest X-Ray:**
Smoke: ☐Never ☐Quit/Year:	Smoked for how many years?
☐Current Smoker	Packs per day: How many years?
Alcohol: ☐Yes For how many years?	Type of drink**:** ☐Beer ☐Liquor ☐Wine
Number of drinks/week:	For how many years?
☐Never ☐Quit/Year:	Drank for how many years years?
Other Drugs: ☐Marijuana ☐cocaine ☐acid ☐speed ☐amphetamine ☐other:	☐**None**

Family History	Alive	Deceased	Age	Describe Illness, if any
Father	☐	☐		
Mother	☐	☐		
Sister	☐	☐		
Sister	☐	☐		
Brother	☐	☐		
Brother	☐	☐		
Mother's Relatives	☐	☐		
Father's Relatives	☐	☐		

Please check any symptoms, diagnosis, treatment or surgeries for the following systems:

General	Fever ☐ Chills ☐ Fatigue ☐ Weight Loss ☐ Loss of Appetite ☐
Eyes	Vision Loss ☐ Light Sensitivity ☐ Blurring ☐ Double Vision ☐ Irritation ☐ Eye Pain ☐
Ear/Nose/Throat	Earache ☐ Tinnitus ☐ Hearing Loss ☐ Nasal Congestion ☐ Nosebleeds ☐ Sore Throat ☐ Hoarseness ☐ Difficulty Swallowing ☐ Post-nasal Drip ☐
Cardiovascular	Chest Pain ☐ Palpitations ☐ Fainting ☐ Excessive Breathing ☐ Swelling in Feet ☐
Respiratory	Cough ☐ Difficulty Breathing ☐ Excessive Mucus ☐ Wheezing ☐
GI	Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain ☐ Yellow Skin ☐ Heartburn ☐
GU	Painful Urination ☐ Blood in Urine ☐ Urinary Frequency ☐ Pelvic Pain ☐ Decreased Libido ☐
Musculoskeletal	Neck Pain ☐ Back Pain ☐ Joint Pain ☐ Swelling ☐ Muscle Cramps ☐ Muscle Weakness ☐ Stiffness ☐ Arthritis ☐ Gout ☐
Dermatological	Rash ☐ Itching ☐ Dryness ☐ Suspicious Lesions ☐
Neurological	Memory Loss ☐ Weakness ☐ Paralysis ☐ Seizures ☐ Syncope ☐ Tremors ☐ Vertigo ☐ Headaches ☐ Mental Changes ☐
Psychiatric	Anxiety ☐ Change in Sleep Habits ☐ Suicidal Thoughts ☐ Hallucinations ☐ Paranoia ☐ Depression ☐
Endocrinologist	Cold Intolerance ☐ Heat Intolerance ☐ Excessive Thirst ☐ Weight Change ☐ Fatigue ☐
Hematological	Enlarged Lymph Nodes ☐ Bleeding ☐ Abnormal Bruising ☐
Allergies:	Hives ☐ Hay Fever ☐ Persistent Infections ☐ HIV Exposure ☐

For Women: *List the month, year and abnormalities, if any.*
Last Menstrual Period:
Are you on contraceptive pills? Yes ☐ No ☐ Plan for pregnancy in the near future? Yes ☐ No ☐
Last Mammogram:
Number of Pregnancies:
Complication during pregnancy, if any:

Medications Pharmacy:

	Medicine	Dose	Number of Pills	How Often	For what?
Example:	*Aspirin*	*81mg*	*1*	*Once daily*	*Stroke*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					

MD Neurology Patient Registration Form

Patient Name: _____ DOB:_____
Address:_____ SSN: _____
City_____ State_____ Zip_____
Home Phone:_____ Work:_____ Cell:_____
Email:_____
Race_____ Preferred Language_____
Emergency Contact: _____ Phone#:_____

Referring Doctor:_____ **Primary Doctor:**_____
Pharmacy:_____ **Pharmacy Phone #:**_____

Insurance Information
Primary Insurance:_____
Subscriber's Name:_____ Relationship:_____
Subscriber DOB:_____ Subscriber SSN:_____

Secondary Insurance:_____ _____
Subscriber's Name:_____ Relationship:_____
Subscriber DOB:_____ Subscriber SSN:_____

If Patient is a Minor, Please Complete the Following:
Father's Name:_____ Mother's Name:_____
Phone #:_____ Phone #:_____

Assignment of Benefits so that we may Facilitate Processing of any Insurance Claim for you and Payment/Credit Agreement:

1) I hereby assign to you, my doctor, all medical and surgical benefits to what I am entitled, including Medicare, private insurance, and any other insurance plan.
2) I hereby authorize said assignee to release all information necessary to secure the payment.
3) I understand that I am financially responsible for all of the charges, whether or not paid by said insurance.
4) I understand and agree that in the event I fail to make payment for services rendered, my name and account may be turned over to an attorney or collection agency and I agree to pay collection agency's fees for collection, court costs, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.
5) This office reserves the right to charge a handling fee for any unpaid balances.

I certify that I have read the above and fully understand it:

Patient Signature:_____ **Date:**_____

I hereby give authorization to any staff member of MD Neurology to release test results and/or medical information to the following persons: (i.e. mother, father, spouse, siblings, daughter, son, etc.)

1)_____ DOB_____
2)_____ DOB_____
3)_____ DOB_____
4)_____ DOB_____

Patient Signature:_____ **Date:**_____

-OR- **I DO NOT** wish to have any of my test results and/or medical information released to anyone other than myself.
Patient Signature:_____ **Date:**_____

Office Policies for MD Neurology

Prescription Refill Policy

- When you need to refill your medicine, please call your pharmacy and have them fax over a prescription refill request to our office, even if you are out of refills.
- If you miss an appt in our office, we are not obligated to fill your medicine.
- Please allow 48 hours to refill any medication.

Outpatient Testing Policy

- Please allow 24-48 hours for our office staff to arrange testing at any outside facility. This time is necessary to preauthorize any testing with your insurance company.
- We often send orders directly to outside facilities so that they may contact you to arrange the appointment at a time that better suits your schedule. If you have not heard from the facility in 48 hours, please contact our office so we may check on the status of your appointment.
- When we receive your test results, you will receive a call from a member of our office staff with the preliminary report. Please remember that this call is a courtesy service and should not be considered medical advice or a substitute for a face-to-face visit with the doctor.

Telephone Message Policy

When leaving a message for our office staff we must pull your chart, review your medical records, discuss a plan of action with the physician, and create legal documentation for the phone call. Please allow an adequate amount of time to return your phone call so that we may provide you with the best possible care.
If you are having an urgent problem, please do not hesitate to go to the Emergency Room.

No Show Policy

- Please give 24-hour notice to our office if you will not be able to make it to your appointment.
- If you fail to give a 24-hour notice to our office that you will not make your appointment, you may be charged $50.
- If you have two no-show appointments within a 12-month period, you will no longer be considered our patient.

Financial Policy

- If you have insurance we will be glad to file the claim for you if we are a part of that network. If your insurance requires that you pay a co-pay, deductible or a coinsurance amount, then that should be paid at the time of service. If you are a self-pay patient, then the amount of the visit or test is to be paid at the time of service. If you do not provide an insurance card you will be considered a self-pay patient.

Referrals

- It is your responsibility to know if we need a referral for your insurance. The referral starts with your Primary Care Physician and is usually required when you have an HMO or POS type of insurance. If no referral has been given and your insurance will not remit payment for our services, you will be responsible for the balance on your account.
- If we have no referral on record at the time of your appointment, that appointment will have to be rescheduled.
- We do not bill third-party insurances (ex: MVA: motor vehicle accidents). The amount due for service will be your responsibility.

I certify that I have read the above and fully understand it:

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

MD Neurology Medical Records Release

Patient Name:_____ DOB:_____
SSN:_____

Do you prefer to be contacted at: ☐work ☐home ☐cell Phone#:_____
May we leave test results on you home voice mail? ☐YES ☐NO

Medical Records Release:

To:_____ Fax#:_____

I hereby authorize you to release the medical records in your possession concerning my illness and/or treatment. Please include any of these that pertain to your facility:

- All scan reports
- Test Results
- Lab Reports
- Dictated History and Physical
- Medication History from Pharmacy

Incorporated in this release form is my authorization for you to include any and all information relating to HIV testing and other AIDS-related treatment or diagnostic techniques.

A copy of the aforementioned records is to be released to:

☐ Jayaraman Ravindran, M.D. ☐ Lynn Wang, M.D.

MD Neurology
4931 Long Prairie Rd, Ste 100 Phone: (972) 420-9200
Flower Mound, TX 75028 Fax: (972) 436-4088

Patient Signature:_____ **Date:**_____

Patient Consent to Use or Disclose Personal Health Information

I understand I have the right to review *MD Neurology's Notice of Privacy Practices* prior to signing this document. The *Notice of Privacy Practices* has been provided to me. (*Patient initials here:*_____). The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information (PHI) that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of MD Neurology. My "protected health information" means health information, including my demographic information (name, address, phone number, and others), that is collected from me and created or received by my healthcare providers or health insurer. This PHI relates to my past, present or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information may identify me. The Notice also describes other potential releases of my PHI that may occur with or without my authorization and my right regarding my health information.

MD Neurology reserves the right to change the privacy practices that are described in the Notice. MD Neurology will provide me with a copy of any revisions to the Notice. The Notice is posted in the reception area of MD Neurology. I may obtain a revised Notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next visit.

I understand that I have the right to request restrictions on how my PHI is used or disclosed to carry out treatment, payment, or MD Neurology's healthcare operations. MD Neurology is not required to agree to the requested restrictions; however, if there is agreement, the restriction is binding on MD Neurology until the agreement is terminated.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations, and acknowledge receipt of our Notice of Privacy Practices.

Patient Signature:_____ **Date:**_____

Description of Authority of Personal Representative: _____