HEALTH QUESTIONNAIRE Date _____

NAME **DOB**

Family Doctor **PLEASE PRINT AS CLEARLY AS POSSIBLE.**

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 _____ (since year _____) High Blood Pressure _____ (since year _____)

High Cholesterol _____ (since year _____) Coronary Artery Disease _____ (year _____)

Cancer (Type) _____ Heart Disease/Stroke _____ Sleep Apnea _____

Head Injury _____ Thyroid Disorder _____ COPD _____

Psychiatric Illness _____ Seizure _____ Colon _____

Dialysis _____ Chronic Kidney Disease _____

Other Illnesses (Please List) _____

Do you have a: ☐ pacemaker? ☐ defibrillator? Blood thinner? ☐ Yes ☐ No

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

Appendectomy _____ Coronary Bypass _____ Hernia _____

Hysterectomy _____ Orthopedic _____ Thyroid _____

Cholecystectomy _____ Spine _____ Hip/Knee Replacement? _____

Others (please list) _____

Drug Allergies:	**Most Recent MRI:** Location:
Occupation (before retirement):	**Educational Level:**
Married / Unmarried / Divorced **No. of Children:**	**Last Chest X-Ray:**
Smoke: ☐ Never ☐ Quit/Year _____. Smoked for _____ years.	
☐ Current Smoker Packs per day_____ How many years? _____	
Alcohol: ☐ Yes For _____ years. Type of drink (beer, liquor, wine) _____	
Number of drinks/week: Since:	
☐ Never ☐ Quit/Year _____. Drank for _____ years.	
Other Drugs: Marijuana, cocaine, acid, speed, amphetamine, other (please explain) **-OR- None**	

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

PLEASE TURN OVER

Please circle any symptoms, diagnoses, 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
Endocrinologic	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					
15					

Patient Registration Form

Patient Name: _____ DOB: ____/____/____
Address: _____ SSN: ____-____-____
City_____State_____Zip_____
Home Phone: _____Work:_____Cell:_____
Email:_____
Emergency Contact: _____Phone#:_____
Race_____ Preferred Language_____

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 Lewisville Neurology, P.A. 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:**_____

MD Neurology, P.A.

Patient Name:_____ **DOB:**_____
SSN:_____

Do you prefer to be contacted at work, home, or by 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:
David H. Cooke, M.D. Jayaraman Ravindran, M.D. Lynn Wang, M.D.
Lewisville Neurology, P.A.
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 *Lewisville Neurology, P.A. 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 the Lewisville Neurology, P.A. 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.

The Lewisville Neurology, P.A. reserves the right to change the privacy practices that are described in the Notice. The Lewisville Neurology, P.A. will provide me with a copy of any revisions to the Notice. The Notice is posted in the reception area of the Lewisville Neurology, P.A. 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 the Lewisville Neurology, P.A.'s healthcare operations. Lewisville Neurology, P.A. is not required to agree to the requested restrictions; however, if there is agreement, the restriction is binding on Lewisville Neurology, P.A. 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:_____

Office Policies for Lewisville Neurology, P.A.

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

6) 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.
7) 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.
8) 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:** _____