NEW PATIENT REGISTRATION FORM

Carolina Neurology Center, PLLC

Aneeta J. Gupta, MD

PERSONAL INFORMATION

Name: ______________________________ **Referring Physician:** ______________________________

Date of Birth: ______________________________ **Emergency Contact:** ______________________________

Social Security #: ______________________________ **Emergency Phone:** ______________________________

Mailing Address: ______________________________ **Emergency Relationship:** ______________________________

City: ______________________________ **Patient's Employer:** ______________________________

State: ____________________ **Zip Code:** __________ **Employer's Address:** ______________________________

Home Phone: ______________________________ **City:** ______________________________

Cell Phone: ______________________________ **State:** ____________ **Zip Code:** ______________

Email: ______________________________ **Occupation:** ______________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby authorize CAROLINA NEUROLOGY CENTER to release any Information necessary for my course of treatment to: "X" indicates information that may be shared with those specific

□ **ANY/ALL INFORMATION MAY BE SHARED Initial** ________

- □ My spouse ______________________ Initial ________
- □ My significant other ______________ **Initial** ________
- □ Other ______________________ **Initial** ________
- □ Leave a message on my answering machine **Initial** ________

- □ Appointment time/date **Initial** ________
- □ Medication(s) **Initial** ________
- □ Radiology/Laboratory results **Initial** ________
- □ Procedure/Surgery Information **Initial** _______

MEDICAL CONSENT: I consent to the examination treatment and procedures which may be performed during the office visit including emergency treatment considered necessary by the physician. If any invasive procedure is necessary, a specific consent form will be discussed with me at that time.

FINANCIAL POLICY: Payment of deductible or co-payment is expected at the time of service. Cash, check, Master Card and VISA are acceptable methods of payment. Insurance claims for each service date will be submitted to your insurance company twice after which time responsibility for payment will be yours.

PAYMENT AUTHORIZATION AND ASSIGNMENT: I hereby authorize CAROLINA NEUROLOGY CENTER to release any information required the course of my examination or treatment. I authorize payment directly to the CAROLINA NEUROLOGY CENTER for the medical/surgical benefits. If, otherwise payable to me for services, I understand that I am financially responsible for the charges not covered by my insurance.

PRINT NAME: ______________________________

SIGNATURE ______________________________ **DATE** ____________________

HEALTH QUESTIONNAIRE

____ DOB___/___/______ Height________ Weight_______

Last First

Unless you instruct us otherwise, a report will be sent to your referring physician and to your primary care physician.

Name of Referring Physician____

Name of Primary Care Physician____

What is the reason for today's visit?

____

____

____

Result of Accident: YES___NO___ If yes, give date(s) and describe: ____

Is this examination to determine disability status for the government or Insurance Company? ____ Yes ____No

Have you had an injury for which there is now a lawsuit pending? ____ Yes ____ No

Are you employed now? _____ Last date worked ____/____/____ Occupation ___________________________________

Duties ____Heavy Lifting ____ Yes ____ No

SOCIAL HISTORY

Marital Status: _______________________

Tobacco ____ Yes ____ No

Amount/Per Day ____________________

# of years: ___________

At what age did you start smoking? _______

Alcohol ____ Yes ____ No

# of years: ___________

Amount, including beer, wine, and liquor ________________________________

Illicit Drugs: ____ Yes ____ No

Caffeine Intake: None Occasional Moderate Heavy

Hand Dominance: Left Right

SURGICAL HISTORY

Please list all surgeries with their date even if unrelated to today's visit:

1) ____ 2) ____

3) ____ 4) ____

5)____ 6) ____

FAMILY HISTORY

	LIVING	AGE	ANY KNOWN MEDICAL CONDITION OR CAUSE OF DEATH
MOTHER	____	_____	____
FATHER	____	_____	____
BROTHER	____	_____	____
	____	_____	____
SISTER	____	_____	____
	____	_____	____
CHILDREN	____	_____	____
	____	_____	____

PATIENT MEDICAL HISTORY:

PLEASE CIRCLE YES OR NO FOR THE FOLLOWING:

ANEURYSM	YES	NO
ANXIETY DISORDER	YES	NO
ARTHRITIS	YES	NO
ASTHMA	YES	NO
BACK PROBLEMS	YES	NO
BLEEDING DISORDER	YES	NO
COPD	YES	NO
CANCER	YES	NO
CORONARY ARTERY DISEASE	YES	NO
DEPRESSION	YES	NO
DIABETES	YES	NO
FIBROMYALGIA	YES	NO
HEAD TRAUMA/INJURY	YES	NO
HEADACHES	YES	NO
HEART ATTACK (MI)	YES	NO
HEART PROBLEMS	YES	NO

HEPATITIS	YES	NO
HYPERTENSION	YES	NO
HYPERTHYROIDISM	YES	NO
HYPOTHYROIDISM	YES	NO
KIDNEY DISEASE	YES	NO
LIVER DISEASE	YES	NO
LUPUS	YES	NO
MIGRIANES	YES	NO
MULTIPLE SCLEROSIS	YES	NO
NECK INJURY	YES	NO
OSTEOPOROSIS	YES	NO
SEIZURES/EPILEPSY	YES	NO
SLEEP DISORDER	YES	NO
STROKE	YES	NO
THYROID PROBLEMS	YES	NO
ULCERS	YES	NO

REVIEW OF SYSTEMS

PLEASE CIRCLE IF YOU EXPERIENCE ANY OF THE FOLLOWING ON A ROUTINE BASIS.

CONSTITUTIONAL

- Fever
- Weight Gain (_______lbs)
- Weight Loss (_______lbs)

EYES

- Vision Change
- Blurred Vision

CARDIOVASCULAR

- Chest Pain
- Palpitations
- Known Heart Murmur

RESPIRATORY

- Cough
- Wheezing
- Shortness of Breath
- Sleep Apnea

GASTROINTESTINAL

- Abdominal Pain
- Vomiting
- Change in Appetite

MUSCULOSKELETAL

- Muscle Aches
- Muscle Weakness
- Joint Pain

NEUROLOGIC

- Headaches
- Migraines
- Dizziness
- Numbness
- Tingling
- Seizures
- Restless Legs

Headache/Migraine Frequency:

____

____

PSYCHIATRIC

- Depression
- Sleep Disturbances
- Restless Sleep
- Alcohol Abuse

ENDOCRINE

- Fatigue
- Hair loss

HEMATOLOGIC/LYMPHATIC

- Excessive Bleeding
- Easy Bruising

ALLERGIC/IMMUNOLOGIC

- Runny Nose
- Itching
- Hives

CURRENT MEDICATION LIST

Patient's Name _______________________________Date of Birth ______/_____/_________

Pharmacy Name & Location

____

Please List Allergies:

____

PRESCRIPTION NAME	MILLIGRAMS (DOSAGE)	HOW DO YOU TAKE IT?	PRESCRIBING PHYSICIAN

Missed Appointment Policy

Effective May 20, 2008, a fee of $25.00 will be charged for all missed appointments (office visits-new and follow-up) and a fee of $100.00 for all missed procedure appointments (EEG, EMG, Sleep Studies) without a prior 24-hour notice. I hereby certify that I have been informed of the office policies of CAROLINA NEUROLOGY CENTER, LLC regarding missed appointments.

____

PRINT PATIENTS NAME DATE

____

PATIENTS SIGNATURE DATE

Financial Guideline Agreement

CAROLINA NEUROLOGY CENTER participates with most insurance plans offered in Western North Carolina. Each plan has different benefits for you, the patient, as well as different financial obligations. We will work with you and your insurance plan to determine what part of your fees for medical care are covered by insurance and which parts are payable by you.

To keep your address and insurance information accurate, we will need to keep a copy of your current insurance card on file. We will ask you to verify this information if it is more than 30 days old (does not apply to Medicare).

ALL MEDICARE PATIENTS WITHOUT A SECONDARY ARE REQUIRED BY LAW TO PAY THEIR 20% COPAY AT THE TIME OF SERVICE.

Fees for medical care that are not covered by your insurance are due at the time of service. These fees include co-payments for managed care plans, annual deductibles and coinsurance as determined by your insurance company. Additionally, you may be responsible for fees that your insurance does not cover.

I understand the above financial policy and that I will be responsible for paying the self-pay balance at each visit. If I am unable to pay in full at the time of service, prior arrangements will be made with the office.

____

PRINT PATIENTS NAME DATE

____

PATIENTS SIGNATURE DATE