MEDICATION LIST

PATIENT NAME ____DOB____________________________

Briefly explain the reason for your visit today: ____

Please list all medication/drug allergies and what reactions you experienced when you took the medication(s).

ALLERGIES:____

____

Please list all the over-the-counter and prescription medications that you take on a regular basis below:

Name of medications and strength of medication	How Taken	When Started	List any adverse reactions or side effects from the medication

{For office use only}	

Dekalb Neurology Group, LLC

Patient's Name________________________ ________________________ ________
Last First M.I.

SS# ________________ Date of Birth _____/_____/_____Sex: M / F Marital Status__________

Preferred Language________________ Race_______________ Ethnicity________________

Home Address ____ Apt#________________

________________ ______ ____________ Email Address:________________________
City State Zip Code

Home # ____________________Work # __________________ Cell # __________________

Referring Physician/Primary Care Physician____

Name of emergency contact__________________ Phone ____________ Relationship__________
not living with you

Primary Insurance Information

Policyholder Name ____________________ Date of Birth_____/_____/_____SS#____________

Insurance Name____

Policy#______________________________ Group#_________________________________

Relationship to Policyholder: Self_______ Spouse_______ Child_______ Other_______

Employer Name ____________________________________
Address ________________________ City______________ State________ Zip____________

Secondary Insurance Information

Policyholder Name ____________________ Date of Birth_____/_____/_____ SS#____________

Insurance Name____

Policy#______________________________ Group#_________________________________

Relationship to Policyholder: Self_______ Spouse_______ Child_______ Other_______

Employer Name ____________________________________
Address ________________________ City______________ State________ Zip____________

Worker's Compensation Insurance (If Appilcable)

Insurance Company Name _________________________ Claim #______________ DOI__________
Address____
Adjuster's Name ____________________________________Phone #____________________

INFORMATION RELEASE: I authorize Dekalb Neurology Group, LLC. to release to my insurance carrier or to the Social Security Administration and Health Care Financing Administration any information needed to determine benefits payable to related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment of benefits apply. Regulations pertaining to Medicare assignment of benefits apply.

Signature:_______________________________ **Date**:_______________________________

Dekalb Neurology Group, LLC

PATIENT PRIVACY ACT NOTICE

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996 (Federal Law). Of significant concern to healthcare organizations is the administrative Simplification Section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction and Code Sets for transmitting data electronically
- Privacy regulation over the disclosure and use of health information
- Security regulations over protection of electronic health information

It is our policy to not release confidential and/or unauthorized information by home telephone, answering, machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we will leave a message of the practice name, telephone number, and contact on the answering machine of your residence. Information will not be left with an unauthorized person. **If you would like to have the information released to someone other than yourself, please complete the following:**

I, ______________________________, hereby authorize Dekalb Neurology Group, LLC and staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone ______________________________

Work Telephone ______________________________

Cell Phone ______________________________

Check here to leave only **NORMAL** test results on voice mail: Yes ____ No ____

I, ______________________________, hereby authorize Dekalb Neurology Group, LLC and staff to fax or mail medical information pertaining to my care to a referred physician, physical therapist, pharmacy, or referring physician, and will assume responsibility to notify your office whenever this information changes:

***Please list the names of people our staff can discuss your medical care with:**

	Print Name	Contact Phone #
Spouse	____________________	____________________
Parent	____________________	____________________
Other	____________________	____________________

Please sign below, acknowledging you have been offered an opportunity to review our Notice of Privacy Practices.

I, ______________________________, have been provided a copy of Dekalb Neurology Group, LLC's Notice of Privacy Practices.

Signature of Patient (Legal Guardian if minor)______________________________Date______________

Dekalb Neurology Group, LLC

FINANCIAL POLICY

To provide the best possible care to ALL of our patients, we must work hard to keep our financial house in order. To achieve this goal, we would like to clarify the financial policy that governs our practice.

1. In order to keep patient accounts current, we require a copy of CURRENT insurance information, as well as photo identification.
2. We are contracted with a number of insurance plans, including many HMO and POS plans. If you are enrolled as a member of an HMO or POS, it is most likely that you require a referral from your primary care physician in order for medical services to be paid. It is the patient's responsibility to obtain any referrals needed PRIOR to being seen. If referrals are not in place by the time of your visit, it will be necessary for the appointment to be rescheduled. We are NOT allowed to get "retroactive" referrals from your primary care physician.
3. Health insurance is a contract between you and the insurance carrier to reimburse you for covered medical services. Insurance coverage and benefits are determined by your contract with the company in which you are enrolled. Patients are responsible for payment of deductibles, coinsurance or copayments at the time of their visit.
4. We are happy to assist patients by filing claims with insurance companies. However, any bills not paid by the insurance remain the responsibility of the patient. This also includes bills for medical procedures and hospital visits.
5. All charges related to the delivery of medical care are expected to be paid promptly and as a guarantor you are responsible for co-pays, deductibles, and any amounts not covered by insurance. In the event a balance becomes past due, late fees of up to 1.5% monthly will apply. We reserve the right to add collection fees of 15% to all accounts placed with our collection representatives.
6. If you are unable to keep your appointment and do not provide the office with 24 hours advanced noticed, you may be subject to a **$25.00 no-show fee**, EMG/NCV diagnostic testing, you may be subject to a **$100.00 no-show fee and $50 no-show fee** for Botox.
7. It is at the discretion of the practice to discharge a patient for behaviors that undermine the patient-doctor relationship, which include non-compliance, abusive behavior towards our staff members, or three consecutive missed appointments.

*If you have any questions, our staff will be glad to assist you in finding the answers.

*I understand the financial policy stated above and that, as a patient, I have certain obligations for my care.

Signature: ______________________________ Date:______________________

Dekalb Neurology Group, LLC

PATIENT NAME:_______________________________ DOB:__________ DATE:__________

Allergies (Drug/Medications): ____

____

Requesting Physician:____

Medical History: Check all that apply

High Blood Pressure	☐	Seizures	☐
Diabetes	☐	Migraines	☐
Stroke	☐	Alzheimer's	☐
Heart Disease	☐	Parkinson's	☐
Cancer	☐	Multiple Sclerosis	☐
HIV	☐		
Other	☐	Explain______________________	

Previous Hospitalizations/Surgeries/Serious Injuries N/A ☐

____

____

Family History: Check all that apply

High Blood Pressure	☐	Relationship to patient______________________
Diabetes	☐	Relationship to patient______________________
Stroke	☐	Relationship to patient______________________
Heart Disease	☐	Relationship to patient______________________
Cancer	☐	Relationship to patient______________________
Epilepsy	☐	Relationship to patient______________________
Multiple Sclerosis	☐	Relationship to patient______________________
Other	☐	Relationship to patient______________________

Social History: Check all that apply

Marital Status:	☐ Married	☐ Single	☐ Separated	☐ Divorced	☐ Widowed
Children:	☐ No	☐ Yes How many and ages______________________			
Alcohol Use:	☐ Previously	☐ Rarely	☐ Moderate	☐ Daily	
Illegal Drug Use:	☐ Previously	☐ Rarely	☐ Moderate	☐ Daily	
Caffeine Use:	☐ Previously	☐ Rarely	☐ Moderate	☐ Daily	
Tattoos:	☐ No	☐ Yes			
Do you smoke:	☐ No	☐ Yes How many per day/week _______For how long _______			
Are you pregnant:	☐ No	☐ Yes			

Occupation:____

Relevant Sexual History:____

Are you currently seeking disability? ☐ No ☐ Yes Explain:______________________

Is this office visit in any way related to an auto or work injury? ☐ No ☐ Yes

Explain:____

Dekalb Neurology Group, LLC

PATIENT NAME:____ DOB:____________ DATE:__________

Check all that apply:

General
- ☐ Fever
- ☐ Weight Loss
- ☐ Weakness
- ☐ Fatigue
- ☐ Sweats

Ear/Nose/Mouth/Throat
- ☐ Hearing impairment
- ☐ Ringing in ears
- ☐ Ear Infections
- ☐ Nosebleeds
- ☐ Bleeding gums
- ☐ Frequent sore throat
- ☐ Prolonged hoarseness
- ☐ Sinus problems
- ☐ Difficulty Swallowing

Musculoskeletal
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Neck pain
- ☐ Back problems
- ☐ Joint pain/Stiffness
- ☐ Arthritis
- ☐ Gout
- ☐ Deformities

Neurological
- ☐ Headaches
- ☐ Head injury
- ☐ Fainting
- ☐ Blackouts
- ☐ Seizures
- ☐ Stroke
- ☐ Dizziness
- ☐ Paralysis
- ☐ Numbness
- ☐ Pain
- ☐ Tingling
- ☐ Burning
- ☐ Tremors
- ☐ Speech problems
- ☐ Unsteadiness of gait
- ☐ Loss of memory
- ☐ Disorientation
- ☐ Behavior change

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Hallucinations
- ☐ Difficulty sleeping
- ☐ Drug abuse

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Palpatations
- ☐ Shortness of breath (with exertion)
- ☐ Shortness of breath (lying flat)
- ☐ Heart attack (history)
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Leg pain
- ☐ Swelling of legs
- ☐ Blood cots

Eyes
- ☐ Blurry vision
- ☐ Double vision
- ☐ Blindness
- ☐ Eye pain/redness
- ☐ Cataracts

Chest
- ☐ Cough
- ☐ Tuberculosis
- ☐ Asthma/Wheezing
- ☐ Coughing up blood

Gastrointestinal
- ☐ Loss of appetitie
- ☐ Excessive thirst
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Ulcers
- ☐ Abdominal pain
- ☐ Change in stools
- ☐ Vomiting blood
- ☐ Rectal bleeding
- ☐ Black, tarry stools
- ☐ Jaundice/Hepatitis
- ☐ Liver disease
- ☐ Gall Bladder disease

Genitourinary
- ☐ Bladder control loss
- ☐ Burning urination
- ☐ Blood in urine
- ☐ Sexual Problems
- ☐ Prostate problems
- ☐ Menstrual problems

Date of last menstrual period:____________

Endocrine
- ☐ Thyroid problems
- ☐ Goiter
- ☐ Diabetes/Blood suger
- ☐ Intolerance to heat/cold

Hematological/Lymphatic
- ☐ History of anemia
- ☐ Tendency to bleed
- ☐ Blood transfusions
- ☐ Swollen glands

Skin/Breasts
- ☐ Rashes/Bruising
- ☐ Changes in hair/nails
- ☐ Breast lumps

Breast pain/discharge

Allergic/Immunological
- ☐ Eczema
- ☐ Hay fever
- ☐ Hives
- ☐ Allergic reactions

☐ NONE OF THE ABOVE

Neurologic:

Frequent Headaches ☐ No ☐ Yes

How often:____

Severity: ____

Precipitating Factors:____

Medications tried and failed:____

Seizures/Convulsions: ☐ No ☐ Yes Last Seizure:______________________________

Stroke/TIA ☐ No ☐ Yes Last Stroke/TIA:______________________________