North Fulton Neurology, P.C.
Patient Registration Form

Patient Last Name:_____ First Name:_____ Middle Initial: ___

Birth Date: _____ SSN:_____ Primary phone:_____

Cell Phone:_____ Email address:_____

Address:_____

Emergency Contact:_____ Phone number:_____

Relation:_____

Employer:_____ Phone number:_____

Employer address:_____

Pharmacy Name_____ Address: _____

Phone Number:_____

Primary Care Physician:_____ Address:_____

Phone number:_____

If physical insurance card is not present, please provide the information below:

Insurance: _____

Member ID/Policy number:_____

Group number:_____

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS ACCURATE AND THAT I HAVE RECEIVED A COPY OF THE OFFICE PROTOCOL FOR NORTH FULTON NEUROLOGY, P.C.

Name:_____ Date:_____

North Fulton Neurology, P.C.

Name:_____ Date:_____

Who referred you to us? _____

Medications:

Medication	Dose	Frequency

Allergies: _____

_____

Past Medical History: Have you ever had the following (check all that apply)

High Blood Pressure	____	Visual Problems	____	Ulcers	____
Stroke	____	Substance Abuse	____	Arthritis (What type?)	____
Seizures	____	Liver Disease	____	Cancer (Location)	____
Parkinson's Disease	____	Diabetes	____	Migraines	____
Neuropathy	____	Thyroid Disease	____	Hepatitis, HIV, TB	____
Vertebral Disc.	____	Heart Disease	____	Kidney Disease	____
Brain Tumor	____	Asthma/Emphysema	____		

Past Surgical History:

Procedure	Date	Surgeon

Family History: Has anyone in your family had the following?

High Blood Pressure	____	Diabetes	____	Stroke	____
Heart Disease	____	Parkinson's Disease	____	Arthritis	____
Alzheimer's Disease	____	Cancer (location)	____	Neuropathy	____
Developmental Delay	____	Migraines	____	Epilepsy	____

Other:_____

Social History:

Occupation:_____ Marital Status:_____

Chemical Exposures:_____ Number of children:_____

Education:_____ Do you smoke?_____

How many packs a day?_____ How many years?_____ Former smoker?_____

How much alcohol do you drink per week? _____

North Fulton Neurology
Symptoms Review

Name:_____ Date:_____

Please check all symptoms that you may have had recently (within the last month)

General:
__ fever
__ weight loss
__ fatigue

Skin:
__ rash
__ itching

Eyes:
__ vision loss
__ double vision

Ears:
__ hearing loss
__ ringing in ears

Nost:
__ nasal congestion

Heart:
__ chest pain
__ palpitations

Gastrointestinal:
__ abdominal pain
__ vomiting
__ diarrhea

Genitourinary:
__ frequent urination
__ decreased sex drive
__ impotence
__ incontinence

Musculoskeletal:
__ joint pain
__ joint swelling
__ muscle aches

Sleeping:
__ insomnia
__ falling asleep during the day
__ snoring

Breathing:
__ shortness of breath
__ cough

Miscellaneous:
__ depressed
__ anxiety
__ loss of appetite
__ other:_____

_____ I HAVE NOT HAD ANY OF THE ABOVE SYMPTOMS RECENTLY.

Office Policy and Procedures

We would like to thank you for making an appointment at North Fulton Neurology. We are aware that each medical practice has different policies and procedures. Becoming familiar with our policies and procedures will help us in our working relationship with you.

1. We require a 24 hour notice prior to an appointment cancellation or rescheduling. There is no charge for canceling an appointment. There is a $25 charge for all missed appointments with no phone call and no voicemail.

2. Co-payments are due prior to your visit with the doctor, including telemedicine appointments.

3. If you have an HMO, POS, or Managed Choice insurance policy, you are responsible for obtaining all referrals and making sure they are valid for every office visit. Our contract with your insurance company may not permit us to see you without a valid referral at the time of service. Without a valid referral, we may have to reschedule your appointment.

4. If you are a Workers Compensation claimant and your claim is denied, you are responsible for payment.

5. If your insurance company does not pay for a service: (A) because it is not a covered service under your plan (B) your plan is not in effect on the date of your visit or (C) because it is a pre-existing condition, you are responsible for payments of these services.

6. Patients being seen as “work-ins” will see the doctor as soon as possible after regularly scheduled patients and per office staff’s discretion.

7. There is a $35.00 service charge for all returned checks. If your account is in arrears and necessitates the use of a collections agency, there will be a flat fee of $25.00 added to your overdue balance.

8. If you have a question or need to leave a message for the doctor please leave a message with anyone in the office or use the message system in the patient portal. Messages will receive a response as soon as possible/within 24 business hours.

9. Prescription refills for controlled substances must be 30 days apart with scheduled appointments at least every 3 months per DEA regulations.

10. Medication refills requested after 4pm on Friday will be handled on the next business day (Monday).

11. The physician has permission to acquire medication histories up to one year from date.

I have read and understand the office policies stated above and agree to accept the responsibility as described.

Name:_____ Date:_____

North Fulton Neurology, P.C.

B.R. Drexinger, M.D.

CONTROLLED SUBSTANCE MEDICINE POLICY
(Please read carefully)

The DEA classifies medications as I-V from most likely to least likely to cause addiction and harm. The DEA can also classify medications as being "controlled". Usually any medication with even a small chance of addictive potential will be classified as a controlled substance. Even some medications that are class V are controlled substances.

1. I agree to take all controlled substances as directed per the physician. I am not allowed to change dosage amounts or alter the medication schedule without first talking to my prescribing physician.
2. I understand that I am subject to up to four random drug tests per year and refusal of drug testing can be reason for dismissal from North Fulton Neurology, P.C.
3. Controlled substances will not be called in after normal business hours or during weekend days.
4. Only one pharmacy will be used for filling controlled substance prescriptions.
5. The following are conditions for **immediate termination** from North Fulton Neurology.
    A. Obtaining a controlled substance prescription from another physician while under the care of North Fulton Neurology and without our knowledge.
    B. Altering or forging of a prescription from the physician, which is a felony and will be reported to the police and the DEA.
6. Patients may be dismissed from North Fulton Neurology, P.C. with 30 days notice for noncompliance in the taking prescription medications.
7. Lost or stolen prescriptions will only be refilled once with a valid police report.
8. I am aware that most manufacturers of drugs used to treat chronic pain recommend against the operation of heavy machinery, including driving a motor vehicle. I am aware that if I choose to drive a motor vehicle I could be charged with a DUI/DWI.
9. In the case of intolerance or ineffectiveness, a different prescription could be given, provided the unused portion of the previous prescribed medications are returned to the pharmacy.
10. I will not consume alcohol at the same time a controlled substance is being taken.
11. I will not give, trade or sell controlled substances.
12. I will allow 24 business hours for prescription refills to be authorized by my pharmacy, and up to 72 business hours for insurance prior authorizations.

I have read and understand the above policy and agree to abide by its terms.

Name:_____ Date:_____

Health Insurance Portability and Accountability Act (HIPAA)

RECEIPT OF NORTH FULTON NEUROLOGY NOTICE PRIVACY PRACTICES

North Fulton Neurology Notice of Privacy Practices provides information about how North Fulton Neurology may use and disclose protected health information about you. As provided in our notice, the terms of our usage may change. If we change our notice, you may obtain a revised copy on request.

By signing below, you acknowledge that you have received a copy of North Fulton Neurology, P.C. office policy and procedures as well as a HIPAA form.

Patient Name: _____

Date: _____

_____

Patient or Responsible Party Signature

North Fulton Neurology
B.R. Drexinger, M.D
1100 Northside Forsyth Dr. Suite 210
Cumming, GA 30041
(770) 751-1589 Fax (678) 807-8819

I, _____, (_____) give the following person(s)
Printed name Date of birth

permission to call via phone and speak to any member of staff about my medical history, condition(s) and records.

1. _____
2. _____
3. _____
4. _____

Doctors:

1. _____ Phone: (_____)_____-_____
2. _____ Phone: (_____)_____-_____
3. _____ Phone: (_____)_____-_____

I authorize the release of any medical information, including related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information with this signed request.

Name: _____ _____
Signature of person giving consent Date signed

Medical records can be sent to:

BR Drexinger, M.D.
North Fulton Neurology
1100 Northside Forsyth Drive
Suite 210
Cumming, GA 30041
Fax: (678) 807-8819
Phone: (770) 751-1589

Thank you for your attention to this request,

North Fulton Neurology