North Fulton Neurology P.C.
Patient Registration Form

Patient Last Name:_____ First Name:_____Middle Initial ____

Birth Date:_____ SS#_____ Phone #_____

Cell Ph#_____ Work:_____

Address:_____ Email Address_____

Emergency Contact: _____ Ph# _____ Relation:_____

Employer:_____ Employer Address:_____

Phone#_____ _____

Pharmacy Name_____ Address: _____

Phone Number:_____

Primary Care Physician:_____ Address:_____

Ph #:_____

Insurance: _____

Member ID: _____

Policy 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? _____

Primary Care Physician: _____ Phone #: _____

Medications:

Medication	Dose	Frequency

Allergies: _____

_____

Past Medical History: Have you every 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 you 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 may 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 lost
__ ringing in ears

Nose:
__ nasal congestion

Heart:
__ chest pain
__ palpitation

__ other

Gastrointestinal:
__ abdominal pain
__ vomiting
__ diarrhea

Genitourinary:
__ frequent u1ination
__ 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

_____ 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 without policies and procedures will help us in our working relationship with you.

l. If you have an HMO, POS, or Manager Choice 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 so we would need to reschedule your appointment.

2. CO-PAYS ARE DUE AT THE TIME OF VISIT

3. If you are an existing Workers Compensation claimant and your claim is denied, you are responsible for payment

4. If your insurance company does NOT PAY: (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.

5. Patients being seen as “work-ins” will see the Doctor as soon as possible after the regularly schedule patients.

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

7. WE REQUIRE A 24 HOUR NOTICE.PRIOR TO AN APPOINTMENT CANCELLATION OR RESCHEDULE. THERE IS A $35.00 FEE IF 24 HOURS IS NOT RECEIVED.

8. If you have a question or need to leave a massage for the doctor please leave a massage with anyone in the office. or use the message system in the patient portal. Massages on are attended to as quickly as possible after the doctor reviews your request or question.

9. PRESCRIPTIONS: should last you until your next scheduled office visit. If there are exceptions, at least a 24 hour notice is required to call in any NONE NARCOTIC prescription. MEDICATION RE-FILL CALLED ON FRIDAY WILL:BE HANDLE THE NEXT BUSINESS DAY (.MONDAY) (see Pain Medication .Policy hand out)

I give my physician permission to acquire my medication history.
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 M.EDICINE POLICY
(Please read carefully)

The DEA classifies medications as I-V from most likely to less likely for addiction and harm, However, it also classifies medications as being a controlled substance or not. Usually any medication with even a very 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 "controlled substance medications" exactly as instructed. I AM NOT allowed to change dosage amounts or alter the time scheduled of taking the medication without first talking to my prescribing physician. I understand that I am subject to a random drug tests and refusal of drug testing can be reason for dismissal from North Fulton Neurology P.C.·
2. Controlled substance medicines WILL NOT be phoned in after business hours or weekends.
3. ONLY ONE pharmacy will be used for filling controlled substance medicine".
4. The following are conditions for IMMEDIATE TERMINATION from North Fulton Neurology.
    A. Obtaining "Controlled Substance Medicine" from ANY other physician while under the care of North Fulton Neurology without our knowledge.
    B. ALTERING or FORGING of a prescription is a FELLONY and wi11 be reported to authorities
5. Patients may be te11ninated from North Fulton Neurology with 30 days notice for noncompliance in the taking of their medications.
6. North Fulton Neurology WILL NOT re-fill prescriptions that have been misplaced, lost.
7. Stolen medications will be replaced ONCE and ONLY if you have a VALID Police Report.
8. In case of Intolerance or ineffective controlled substances a different prescription could be given, provided unused portion of previous prescribed medications is returned.
9. I AM AWARE that most of the manufactures of drugs used to treat chronic pain recommend AGAINS the operation of heavy equipment, which includes driving a motor vehicle. I AM AWARE that if I choose to drive a vehicle I could be charged with a DUI.
10. I WILL NOT combine any controlled substance medications with the consumption of alcohol.
11. I WILL NOT give, trade or sell controlled substances
12. I WILL allow 24 hours for prescription refills to be authorized. I also understand any request received after 4:00PM are handle the next business day.

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 many use and disclose protected health information about you. As provided in our notice, the terms of our notice 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. and HIPPA documentation.

Patient Name: _____

Date: _____

_____

Patient or Responsible Party Signature