North Fulton Neurology P.C.
Patient Registration Form

Patient Last Name:________________________ **First Name:**___________________ **Middle Initial :**___________

Date Of Birth:___________________________**SS#**______________________________________

Address:______________________________________ **Email Address**_________________________________

Emergency Contact:_______________________**Ph#**_______________________**Relation:**______________

Cell Ph #__________________________________**Work #**_______________________

Employer:______________________________ **Employer Address:**________________________________

Phone #_________________________________ ____

Pharmacy Name__________________________ **Address:**_____________________________________

Phone Number:___________________________

Primary CarePhysician:______________________**Address:**__________________________________

Ph #:____________________________________

Insurance :___________________________

Member ID:___________________________

Policy Number :_________________________

I ACKNOWLEDGE THATG 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
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

Gastrointestinal:
__abdominal pain
__vomiting
__diarrhea

Genitourinary:
__frequent urination
__incontinence
__impotence
__decreased sex drive

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.

North Fulton Neurology

Name: ______________________ Date: ____________

Who referred you to us? ______________________

Primary Care Physician: ______________________ Phone #: ____________

PAST HISTORY: Have you ever had the following? (Check all that apply)

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

MEDICATIONS TO WHICH YOU ARE ALLERGIC: ______________________

____

FAMILY HISTORY: Has any family member 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: ______________________

____

____

List all the medications you are currently taking:

NAME OF MEDICATION	DOSE	HOW OFTEN IS IT TAKEN?
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______

Social History:

Occupation: ______________ Marital Status: ______________

Chemical Exposures? ______________ Number of children: ______________

Last Grade completed in school? ______________ Do you smoke? ______

How many packs per day? ____ How many years? ____ Former Smoker? ______

How much alcohol do you drink per week? ______________________

List all surgeries you have had (including dates): ______________________

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North Fulton Neurology
B.R. Drexinger, M.D.

In the event our physician needs to prescribe "Controlled Substance" medication for your condition, we have the following policy.

CONTROLLED SUBSTANCE MEDICINE POLICY
(Please read carefully)

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 my drug test can be reason for dismissal from North Fulton Neurology, P.C.
2. "Controlled Substance Medicine" WILL NOT be phoned in after business out 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 will be reported to authorities.
5. Patients may be terminated 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 Substance Medication" 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, with 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 Substance Medications"
12. I WILL allowed 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:________________________

Office Policy and Procedures

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

1. 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 does 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 $25.0 added to9 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 want to ask a HEALTH RELATED question or need to leave a massage for the doctor please leave a massage with anyone in the office. Massage on are attended to as quickly as possible after the doctor reviews your request of question.

9. PRESCRIPTIONS: should last you until your next schedule office visit. For any 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:______________________

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 by requiesting a copy.

By signing below, you acknowledge that you have received a copy of North Fulton Neurology and HIPPA copies.

Patients Name: ______________________________

Date: ______________________________

Patient/Responsible Party Signature

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