PATIENT REGISTRATION

Patient's Last Name_______________________________First:____________________________Middle Init:____________

Address:____

City:________________________________ST:_____Zip:_______________Home Phone:(____)______-______________

Cell Phone:(____)______-_______________ Work Phone:(____)______-_______________ Ext:____________________

Employer:_________________________________ Employer address:____

Email Address:____Preferred Contact: _____Home_____Cell_____Work

Birth Date:M___ ___/D____ _____/Y_____ _____ Soc Sec No:___ ___ ___-___ ___-___ ___ ___ ___ Sex:M____F____

Preferred Language__________________________ Ethnicity____________________________ Race__________________

In emergency, contact:____ Phone (_____) ________-__________________

Spouse's Name: ____ Spouse's Birth Date: ____/____/_____

Spouse's Employer: _________________________________Spouse's Soc Sec No ___ ___ ___-___ ___-___ ___ ___ ___

Primary Care Physician: ____ Phone (_____) ________-__________________

Insurance:____Policy Holder's Name:_____________________________________

Address (for claims):____________________________________City:____________________ST___Zip_______________

Policy ID#:______________________________ Group #:________________ Policy Holder's Birth Date____/____/____

Relationship to Policy Holder: Self______Spouse______Parent______Step-Parent______Other____________________

Secondary Insurance:_________________________________Policy Holder's Name: ________________________________

Address (for claims): ____________________________________City:____________________ST___ Zip______________

Policy ID#:______________________________ Group #:________________ Policy Holder's Birth Date ____/____/____

Relationship to Policy Holder: Self______Spouse______Parent______Step-Parent______Other____________________

<u>If patient is Child under 18, Responsible Party:</u> ____

Address: ____ Phone No:(____) ______-________

Employer: ____ Work Phone: (____) ______-_____________ Ext: ___________

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.

DATE: M___ ___/D___ ___/Y___ ___ **X**____

(Signature) **(REVISED 02/12)**

North Fulton Neurology, P.C.

Name: ______________________________ **Date**: ______________

Pharmacy Used ____________________ **Referred by:** __________________

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: ____

____

____

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 the medications you are currently taking:

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

List all surgeries (not procedures): ______________________________

____

____

NORTH FULTON NEUROLOGY

REVIEW OF SYMPTOMS

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
___ visual loss
___ double vision

EARS
___ hearing loss
___ ringing in ears

NOSE
___ nasal congestion

BREATHING
___ shortness of breath
___ cough

HEART
___ chest pain
___ palpitations

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

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 with our office. 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. If you have an HMO, POS, or Managed 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 payment of these services.

5. Patients being seen as "work-ins" will see the Doctor as soon as possible after the regularly scheduled patients.

6. There is a $35.00 service charge for all returned checks. If your account is in arrears and necessitates the use of a collection 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-hour notice is not received.

8. If you want to ask a health-related question or need to leave a message for the doctor please leave a message on the doctor/nurse voicemail. Messages are attended to as quickly as possible after the doctor reviews your request or question. Listen to the phone menu to choose the appropriate voicemail.

9. Prescriptions should last until your next scheduled office visit. For any exceptions, at least a 24 hour notice is required to call in any prescription refills. Calls made on Friday may not be filled until Monday. NO narcotic medications will be prescribed over the phone after office hours. (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 above.

Signed ____ Date______________________
(Patient or Patient's legal representative)
(revised August 15, 2012)

In the event our physician needs to prescribe "controlled substance" medications for your condition, we have the following policy.

CONTROLLED SUBSTANCE MEDICINE POLICY

(Please read carefully and sign at the bottom. A copy will be provided to you.)

1. **I agree** to take controlled substance medication exactly as instructed. **I am NOT allowed** to change dosage amounts or alter the time schedule of taking the medication without first talking to my prescribing physician. I understand that I am subject to random drug tests and refusal of any drug tests can be reason for dismissal from North Fulton Neurology, P.C.
2. Controlled substance medications **WILL NOT** be phoned in after business hours or on weekends.
3. **Only ONE** pharmacy will be used for filling controlled substance prescriptions.
4. The following are conditions for **IMMEDIATE TERMINATION** from the practice:

a. Obtaining controlled substance medications from ANY other physician while under our care without our knowledge.
b. Altering or forging of a prescription is a felony and will be reported.

5. Patients may be terminated from the practice with 30 days notice for noncompliance in the taking of their medication.
6. We will **NOT** refill prescriptions that have been lost or misplaced. Please be responsible for keeping up with your controlled substance prescription.
7. Stolen medications will be replaced **ONCE** and **ONLY** if you have a valid police report.
8. In the case of intolerance or ineffective controlled substance medications, a different prescription could be given, provided the unused portion of the previously prescribed medication is returned.
9. **I am aware** that most of the manufactures of drugs used to treat chronic pain recommend **AGAINST** 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 substance medications.
12. **I will allow** 24 hours for prescription refills to be authorized. **I also understand** that request received after 4:00pm are handled on the next business day.

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

_______________________________ Patient Signature

_________________ Date

Health Insurance Portability and Accountability Act (HIPAA) Privacy Compliance

RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may 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 requesting a copy at our office or by downloading a copy from our web page www.northfultonneurology.com.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name ____

Date ____

Patient / Responsible Party Signature ____________________