Lawrenceville Neurology Center Patient Registration Form

DATE: ______________________

NAME: ____
First Middle Initial Last

ADDRESS: ____
Street/Box Apt # City State Zip

PHONE: (___) ______________ WORK: (____) _______________ CELL: (___) ________________

EMAIL ADDRESS: ___________________________________ OCCUPATION: ____________________

SEX: □ MALE □ FEMALE AGE: _____ DATE OF BIRTH: __________ SOC. SEC. #: ______________________

LANGUAGE: ___________________________ RACE/ ETNICITY: ____

MARITAL STATUS: □ SINGLE □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED
□ DOMESTIC PARTNER □ CIVIL UNION

SPOUSE'S / PARENT'S NAME: ______________________ CONTACT NUMBER: (__) ________________

EMERGENCY CONTACT NAME: _____________________ CONTACT NUMBER: (___) ________________

REFERRING DOCTOR: ____________________________ PHONE NUMBER: (___) ________________

ALLERGIES: Yes or No (please Circle and list, if any)____

INSURANCE INFORMATION
PRIMARY INSURANCE & ID #: ____
NAME OF INSURANCE **IDENTIFICATION #**

NAME OF INSURED: ________________________________ INSURED'S DATE OF BIRTH: __________
MANDATORY

SECONDARY INSURANCE: ____
NAME OF INSURANCE

NAME OF INSURED: ________________________________ INSURED'S DATE OF BIRTH: __________
MANDATORY

ACCIDENT INFORMATION – PLEASE NOTIFY THE FRONT DESK IF THIS IS ACCIDENT RELATED AS WE NO LONGER SEE PATIENTS FOR MVA/W. COMP RELATED INJURIES

□ AUTO □ WORKMEN'S COMPENSATION DATE OF ACCIDENT / INJURY: _______________

CASE MANAGER NAME/PHONE NUMBER: ____

ADJUSTERS NAME/PHONE NUMBER: ____

POLICY NUMBER: ___________________ INSURANCE COMPANY'S NAME/ADDRESS:
____

RELEASE OF INFORMATION / PAYMENT AUTHORIZATION/ASSIGNMENT OF BENEFITS/NO SHOW POLICY

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I assign direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance and that any payments due not covered by insurance over 120 days old will be charged a 15% late fee. I certify that the information I have reported to be correct. In addition, I understand that I may be billed a $25.00 no show fee for all missed appointments without prior notification.

______________________________________ ______________________________
SIGNATURE **DATE**

FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance company for my visits. This includes any medical service visit, EMG, EEG, Sleep Deprived/Video/Ambulatory EEG's, Evoked potentials, Transcranial Doppler, Carotid Duplex and Neuropsych testing ordered by my physician or the physician's staff.

I understand and agree it is my sole responsibility and not the responsibility of the provider of services or technicians to know if my insurance will pay for my medical service, testing or visit ordered by my physician or the physician's staff.

I understand and agree it is my sole responsibility to know if my insurance has any deductibles, referral requirement, co-payment, co-insurance, out-of-network amount and usual and customary limit or any other type of benefit limitation for the services I receive, and I agree to make full payment promptly.

I understand that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied, or a higher out-of-pocket expense to me. I understand this and agree to be financially responsible and make full payment promptly.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment promptly.

By signing below, I agree to accept full financial responsibility as a patient who is receiving any medical services, that may include EMG, EEG, Sleep Deprived/Video/Ambulatory EEG's, Evoked potentials, Transcranial Doppler, Carotid Duplex and Neuropsych testing or as the responsible party for minor patients. My signature verifies that I have read the above disclosure statement, understand my responsibilities and agree to these terms.

Patient
Signature____Date____________________
Responsible Party Name (please print)____
Responsible Party Signature_____________________________Date___________________

LAWRENCEVILLE NEUROLOGY CENTER, P.A.

Neurology • Neurophysiology • Neuromuscular • Epilepsy • Stroke

Rene Gomez, M.D., F.A.A.N.*

Paul K. Kaiser, M.D.*+◊
Aissa Alexeeva, M.D. *+◊
Kimberly Palangio, D.O.*◊

Manuel Vergara, M.D. *+◊≠
C. Rao, M.D., MRCP, (UK), DM *◊~≠
Nidhi S. Modi, M.D. *

3131 Princeton Pike
Building 3 • Suite 202
Lawrenceville, NJ 08648
(609) 896-1701 • Fax (609) 896-3735

10 Forrestal Road South
Suite 202
Princeton, NJ 08540
(609) 688-3492 • Fax (609) 688-3493

Neuroscience Center for Care - UMCPP
1 Plainsboro Road
Plainsboro, NJ 08536
(609) 853-7020 • Fax (609) 853-7531

I ____ have informed Lawrenceville Neurology Center that the treatment/services I am receiving starting ____________________________ are not the result of an automobile accident or work-related. The problem/condition for which I am seeking treatment/services do not arise from an auto/work related accident.

I ____ understand that by my notifying Lawrenceville Neurology Center that this is not motor vehicle/work related, that any bills incurred but not covered by my personal health insurance will be my personal responsibility and obligation to pay.

We at Lawrenceville Neurology Center ask that you sign this document only after any questions you may have concerning its content have been answered to your satisfaction and you understand your obligation to pay for any unpaid services by your insurance carriers.

_______________________________________ _______________________________
Patient Signature Date

Thank you,
Lawrenceville Neurology Center

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Lawrenceville Neurology Center, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Lawrenceville Neurology Center's P.A. Notice of privacy practices for a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lawrenceville Neurology Center, P.A. reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office at 3131 Princeton Pike Bldg. 3C Suite 202, Lawrenceville, NJ 08648.

With my consent, Lawrenceville Neurology Center, P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I wish to be contacted in the following manner (check all that applies):

□ **Home Telephone ______________________**
- □ O.K. to leave a message with detailed information
- □ Leave a message with name of practice and call back number only.

□ **Work Telephone ______________________**
- □ O.K. to leave a message with detailed information.
- □ Leave message with name of practice and a call back number only.

□ **Email address: _______________________________________**
- □ O.K. to communicate via email address provided above.

□ **Cell Phone/Text Messaging _____________________________**
- □ O.K. to leave a message/text with detailed information
- □ Leave a message/text with name of practice and call back number only.

I grant permission for you to discuss my care with the following person(s)

Name_____________________________Relationship________________Phone #_______________________
Name_____________________________Relationship________________Phone #_______________________

By signing this form, I am consenting to Lawrenceville Neurology Center's, P.A. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Lawrenceville Neurology Center, P.A. may decline to provide treatment to me.

Each dated signature is valid for one (1) year*

_____________________________________ _____________________________
PRINT PATIENT NAME **DATE**

_____________________________________ _____________________________
SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**

_____________________________________ _____________________________
SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**

_____________________________________ _____________________________
SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**

MEDICATIONS

Please list all medications you are currently taking, including non-prescription medications

Patient Name ____

Address ____

____

Phone # ____

Pharmacy
Name & Phone # ____

Name of Medication	Strength	Frequency	Date Discontinued	Signature & Date

DRUG ALLERGIES: **(Please circle and list, if any)**

____

____

Health History

Name: ______________________ Date: ______________

Primary Doctor: ______________________

Past Medical History: Please check all that apply to you

- □ Arthritis
- □ Asthma
- □ Cancer, Type: ______
- □ Depression
- □ Diabetes
- □ Epilepsy/Seizures
- □ Head Trauma/Concussion
- □ Headaches/Migraines
- □ Heart problems : Type______
- □ Heart Surgery
- □ Defibrillator
- □ Pacemaker
- □ High Blood Pressure
- □ Psychiatric disease
- □ Stroke
- □ Thyroid
- □Ulcer/GERD
- □ Blackouts
- □ High Cholesterol
- □ Other:

Allergies to medications: ______________________

Previous Surgeries and/or Hospitalizations: Please list past surgeries with approximate date:

____

____

____

____

Serious Injury: ______________________

____

____

Social History:

Occupation: ______________________

Marital Status: ______________ Children: ______________

Do you drink alcohol? □Yes □No If yes, how much/week? ______________

Do you smoke? □Yes □No If yes, how many cigarettes/day? ______________

□ Former Smoker □ Never Smoker

Do you consume caffeine? □Yes □No If yes, how many cups/day? ________ □coffee □tea □soda

Do you use recreational drugs? □Yes □No If yes, what type and frequency? ______________

Are you on a special diet? □Yes □No If yes, please describe? ______________

Do you exercise regularly? □Yes □No

Family History: Do you know of any blood relative who has or had:

Condition	Relation	Condition	Relation
□ Arthritis	______	□ Kidney disease	______
□ Asthma	______	□ Lung disease	______
□ Aneurysm, Type:	______	□ Migraine	______
□ Brain tumor	______	□ Multiple Sclerosis	______
□ Cancer, Type:	______	□ Parkinson's	______
□ Dementia/Alzheimer's	______	□ Peripheral Neuropathy	______
□ Diabetes	______	□ Psychiatric disease	______
□Epilepsy/Seizures	______	□ Stroke	______
□ Headaches	______	□ Thyroid	______
□ Heart Problems	______	□ Other:	______
□ High Blood Pressure	______		

Comments: ______________________

____

____

General Health History

Review of Systems

As you review the following list, please select any problems that you are experiencing at present.

General Health
- ☐General good health
- ☐Fatigue
- ☐Fever/Chills
- ☐Insomnia
- ☐Change in appetite
- ☐Weight change

Skin
- ☐Ulcers
- ☐Rash
- ☐Itching
- ☐Hives
- ☐Cancer

Ears/Nose/Throat/Mouth
- ☐Ringing of the ears
- ☐Loss of hearing/Deafness
- ☐Earache
- ☐Nasal congestion
- ☐Nose bleeds
- ☐Loss of smell
- ☐Difficulty swallowing

Eyes
- ☐Pain
- ☐Discharge
- ☐Redness
- ☐Loss of vision
- ☐Blurred vision

Respiratory
- ☐Shortness of breath
- ☐Wheezing
- ☐Dry cough
- ☐Productive cough
- ☐Coughing up blood

Heart
- ☐Chest pain
- ☐Palpitations
- ☐Swelling in legs/feet/ankles
- ☐Shortness of breath when lying down (orthopnea)
- ☐Loss of consciousness
- ☐PND (awake from sleep unable to breath)
- ☐MI (heart attack)

Gastrointestinal
- ☐Heartburn
- ☐Constipation
- ☐Diarrhea
- ☐Vomiting
- ☐Bloating
- ☐Abdominal pain
- ☐Bloody stools
- ☐Peptic ulcer disease
- ☐Nausea
- ☐IBS

Genitourinary/Female
- ☐Blood in Urine
- ☐Frequent urination
- ☐Urgency in urination
- ☐Nocturnal urination
- ☐Irregular periods
- ☐Vaginal discharge
- ☐Pelvic pain
- ☐Heavy periods
- ☐Flank pain (between upper and lower back)
- ☐Dsymenorrhea (painful periods)

Genitourinary/Male
- ☐Blood in urine
- ☐Frequent urination
- ☐Urgency in urination
- ☐Nocturnal urination
- ☐Penile discharge
- ☐Testicular pain
- ☐Dysuria (painful urination)
- ☐Impotence
- ☐Rash
- ☐Flank pain (between upper and lower back

Endo
- ☐Breast enlargement
- ☐Low blood sugar
- ☐Diabetes
- ☐Abnormal hair growth
- ☐Steroid use
- ☐Excessive thirst
- ☐Weight gain
- ☐Urinate frequently

Musculoskeletal
- ☐Joint pain/stiffness
- ☐Back pain
- ☐Neck pain
- ☐Difficulty walking
- ☐Muscle pain
- ☐Swelling

Neurological
- ☐Dizziness
- ☐Loss of consciousness
- ☐Weakness
- ☐Headaches
- ☐Numbness/tingling
- ☐Altered mentation
- ☐Seizures
- ☐Memory loss
- ☐Loss of coordination
- ☐CVA

Psychiatric
- ☐Anxiety
- ☐Depression
- ☐Stress
- ☐Mood swings
- ☐Hallucinations
- ☐Delusions

Hematological/Lymph Nodes
- ☐Anemia
- ☐Easy bruising
- ☐Abnormal bleeding
- ☐Swollen lymph nodes

☐ **None of Above**

☐ **Other**

____

____

____

Name:

Date: