Mid-Atlantic Neurology Consultants

8021 Ritchie Hwy
Pasadena, MD 21122

3290 N Ridge Rd Suite 240
Ellicott City, MD 21043

20 Crossroads Drive, Suite 106
Owings Mills, MD 21117

Phone: 410-590-4616 **Fax: 410-590-4618**
www.midatlanticneurology.com

Patient Information

Name:________________________________ Date of Birth: __________________________________
Address:______________________________ Home Phone: __________________________________
______________________________ Cell Phone: __________________________________
Sex: Male Female Age: ____
Marital Status: ________________________ Social Security Number ________________________
E-mail: _______________________________ Occupation: ____________________________________

Who is your Primary Care Physician (PCP)? ____
Who is your Referring Physician (if different than your PCP)?__________________________________

List of people who you authorize our physicians to discuss your medical conditions with:
Name/Relationship/Phone#
____
____

In case of Emergency, who should we contact? ____
Relationship to Patient __________________ Phone number ______________________

Are we able to leave a message on your voicemail regarding medical results? YES NO

Local Pharmacy Name: ______________________ Location: ________________________________
Mail Order Pharmacy Name (If applicable)? ____

Which laboratory do you use for blood draws? ____
Which diagnostic imaging facility do you use? ____
(i.e. for MRIs, CT, X-rays)

Insurance Information

Primary Insurance Company: ____
Policy Number: ______________________________ Group Number: _________________________
Policy Holder Name: ________________________ DOB: _______ Relationship: ______________

Secondary Insurance Company: ____
Policy Number: ______________________________ Group Number: _________________________
Policy Holder Name: ________________________ DOB: _______ Relationship: ______________

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Insurance and Payment Policy

We are committed to providing you with high quality medical care. We will facilitate the handling of your medical claims by completing insurance forms for you and accepting direct payment from your insurance carrier. In order to service your insurance needs, we require your understanding of our payment policy.

Please realize that:

1) We cannot guarantee that your insurance company will pay your claims. It is your responsibility to know your coverage based on your insurance plan**.** If your plan requires a referral from your primary, it is your responsibility to provide the referral or payment must be made at the time of the visit.
2) You are expected to provide complete and accurate information; this includes your full name, address, home telephone number, date of birth, social security number, email address, photo ID and your most up to date insurance card. Our staff is fully compliant with all the Health Information Portability and Accountability Act (HIPPA) regulations.
3) If you receive a monthly billing statement from our office, all outstanding balances are due within **30 days** of receiving your statement.
4) We require that you pay your co-pay at the time of your appointment.
5) We reserve the right to charge the guarantor a **$30.00** fee for missed appointments and **$50.00** fee for studies canceled with less than 24 hour notice. There will be a **$35.00** charge for all returned checks

Credit Card On File

All patients are required to keep a credit card on file for any outstanding deductible, co-pays or not covered amounts from your insurance carrier. Your credit card will be securely saved in our electronic health record system and no physical copy of your card information will be kept in the office for your protection. You will notified 5 days in advance (via email) for any charges that would be made from our office. If you would elect to pay these charges via another payment method simply call our billing department and we can make those arrangements immediately.

Initials __________

Patient Consent Form

I understand under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct healthcare operations such as quality assessments and physician certifications

I have the right to review the *Notice of Privacy Practices* documentation for a complete description of the uses and disclosures of my health information prior to signing this consent. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed. I also understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature:____ Date:____

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Name:________________________________ Reason for Visit:________________________________

Past Medical History

Current medications - Doses and Frequency

Surgical History

Year	Procedures	

Family History

Whom	Health Problems	
Mother		
Father		
Brothers		
Sisters		
Grandparents		
Children		

Allergies: ____

Social History:

Which hand do you write with? Right Left Both

Tobacco history: Current smoker?___________ Age Started?__________ Year Quit?____________________________
How many packs/cigarettes per day?____

Alcohol history: Do you drink alcohol? Y / N If yes, how much? ____
Did you ever drink heavily in the past? Y / N If yes, when did you quit?____________________

Drug history: Do you use recreational drugs? Y / N
If yes, what type and frequency?____

Review of Symptoms

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Fevers
- ☐ Exercise intolerance
- ☐ Pallor

Eyes
- ☐ Vision Changes
- ☐ Dry eyes

Ear, Nose & Throat
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Sinus problem
- ☐ Bleeding gums

GI
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Vomiting

GU
- ☐ Difficulty w/ urination
- ☐ Bladder incontinence

Musculoskeletal
- ☐ Joint swelling
- ☐ Joint pains
- ☐ Low back pain
- ☐ Muscle aches/pains
- ☐ Muscle tenderness

Psychiatric
- ☐ Depression
- ☐ Anxiety

Neuro
- ☐ Headaches
- ☐ Numbness / Tingling
- ☐ Arm or leg weakness
- ☐ Loss of balance
- ☐ Vertigo
- ☐ Dizziness
- ☐ Tremors
- ☐ Loss of consciousness
- ☐ Restless legs

Lymph/Blood
- ☐ Easy bruising

Cardiac / Pulmonary
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Cough / Wheezing

Sleep
- ☐ Dry mouth on waking
- ☐ Side sleeping
- ☐ Morning headaches
- ☐ Non-refreshing sleep
- ☐ Snoring
- ☐ Stop breathing at night
- ☐ Daytime sleepiness
- ☐ Wake up choking
- ☐ Nightmares
- ☐ Violent dreams
- ☐ Hallucinations
- ☐ Kicking / Punching
- ☐ Limb movements

Endocrine
- ☐ Fatigue

Skin
- ☐ Rashes

General Questions:

1) Do you have a Pacemaker/Defibrillator? YES NO
2) Are you currently pregnant? YES NO
3) Do you have metal implants? YES NO

Previous Testing:

Have you ever had an: (If yes, where and when)				
	MRI Brain / MRA?	YES	NO	______________________________
	MRI Spine?	YES	NO	______________________________
	Nerve Conduction / EMG?	YES	NO	______________________________
	Lumbar Puncture?	YES	NO	______________________________
	Carotid Doppler?	YES	NO	______________________________
	Cerebral Angiogram?	YES	NO	______________________________
	Sleep studies?	YES	NO	______________________________
	EEG?	YES	NO	______________________________

Additional Relevant Information:____

____
____
____
____

Patient Portal Agreement

Through our Electronic Health Record (EHR), I will have access to the 'Patient Portal' for obtaining my medical data. Information provided on the 'Patient Portal' is provided "AS-IS" and without any warranty as to its reliability, accuracy, timeliness, usefulness or completeness. The practice assumes no responsibility for any circumstances arising out of the use, misuse, interpretation or application of any information supplied on this site, but will endeavor to protect the privacy of all individuals. Please allow up to 3 business days for a reply if a message is sent via the ' Patient Portal'. If you do not get a response in that time frame, please contact the office directly at 410-590-4616.

The data above has been filled out to the best of my knowledge ____

Patient's Signature Date