



# NEUROLOGY & SLEEP CLINIC PLC.

Office Use Only  
 New Patient  
 EMG/NCV  
 Disability Exam

Dictation Done : \_\_\_\_\_

**TREATMENT OF:**

- Dementia
- Epilepsy
- Headaches
- Medical Retina
- Multiple Sclerosis
- Neurology
- Neuro-Ophthalmology
- Parkinson's Disease
- Retinopathy
- Sleep Disorders

## New Patient Intake Form

Anil Dhuna, M.D.,  
F.A.A.S.M., F.A.A.N.  
Spriha Pavuluri, M.D.  
Jugal Raval, M.D.  
Katie Bentler, PA-C  
Kelley Dawley, ARNP

Date: \_\_\_\_\_ Patient ID: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Handedness: Right \_\_\_\_ Left \_\_\_\_ Ambidextrous \_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date symptoms began: \_\_\_\_\_

Main reason for your visit: \_\_\_\_\_

Describe briefly your present symptoms (problems): \_\_\_\_\_  
\_\_\_\_\_

Previous treatment for this problem (include therapy, surgery and medications)  
\_\_\_\_\_

Date of most recent blood test: \_\_\_\_\_ Where? \_\_\_\_\_

Recent X-rays/MRI/CT (circle): When? \_\_\_\_\_ Where? \_\_\_\_\_

Date of most recent eye exam: \_\_\_\_\_ Where? \_\_\_\_\_

Pneumonia vaccine in the past? \_\_\_\_ Yes \_\_\_\_ No Flu vaccine in the past year? \_\_\_\_ Yes \_\_\_\_ No

**MEDICATIONS:**

Name of Drug	Dose	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Drug Allergies:**

Drug	What reaction?
_____	_____
_____	_____
_____	_____

**PAST MEDICAL HISTORY:**

Do you have or have you had these medical conditions:

- |   |  |
|---|--|
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Tremor                  |
| <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Autoimmune disease      |
| <input type="checkbox"/> Atrial fibrillation  | <input type="checkbox"/> Osteoarthritis          |
| <input type="checkbox"/> CHF                  | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Anxiety disorder        |
| <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Migraine/headache       |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> Thyroid Dysfunction  | <input type="checkbox"/> Stroke syndrome         |
| <input type="checkbox"/> COPD                 | <input type="checkbox"/> Polyneuropathy          |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Dementia                |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Motion sickness         |
| <input type="checkbox"/> GI Disorder          | <input type="checkbox"/> Restless Legs           |
| <input type="checkbox"/> Kidney disorder      | <input type="checkbox"/> Obstructive sleep apnea |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Macular Degeneration    |

Other: \_\_\_\_\_

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**PREVIOUS OPERATIONS:**

- |  |  |
|--|--|
| <input type="checkbox"/> Carotid artery surgery  | <input type="checkbox"/> Hysterectomy  |
| <input type="checkbox"/> Heart Valve replacement | <input type="checkbox"/> Appendectomy  |
| <input type="checkbox"/> Carpal tunnel release   | <input type="checkbox"/> Back Surgery  |
| <input type="checkbox"/> Knee replacement        | <input type="checkbox"/> Brain surgery |
| <input type="checkbox"/> Hip Replacement         | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Gall bladder removal    | <input type="checkbox"/> Pacemaker     |

Other surgery:

\_\_\_\_\_

**SOCIAL HISTORY:**

Marital status: (circle) Never married Married Divorced Separated Widowed

Do you smoke? (circle) yes no

How much? \_\_\_\_\_ cigarettes/ packs a day (circle one)

Given counsel to abstain? (circle) yes no.

How much alcohol do you drink? \_\_\_\_\_ per day \_\_\_\_\_ per month

Illicit drug use (circle): yes no.

If yes, what and how often: \_\_\_\_\_

Occupation: \_\_\_\_\_

Do you live alone? (circle) yes no.

If no, with whom and what is his/her relationship to you? \_\_\_\_\_

**FAMILY HISTORY:**

Mother - 1 Father - 2 Brother - 3 Sister - 4

Please note with the above numbers if a member of your family has been diagnosed with:

Coronary artery disease	1 2 3 4	Migraine/headache	1 2 3 4
Congestive heart failure	1 2 3 4	Epilepsy	1 2 3 4
Hypertension	1 2 3 4	Stroke Syndrome	1 2 3 4
High cholesterol	1 2 3 4	Dementia	1 2 3 4
Diabetes	1 2 3 4	Parkinson's Disease	1 2 3 4
COPD	1 2 3 4	Restless leg syndrome	1 2 3 4
Cancer	1 2 3 4	Obstructive sleep apnea	1 2 3 4
Depression	1 2 3 4	Tremor	1 2 3 4

Patient Number \_\_\_\_\_

**REVIEW OF SYSTEMS: (CURRENT COMPLAINTS)**

<b>Systemic Symptoms</b> <input type="checkbox"/> Weight Change <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Other constitutional	<b>Pulmonary Symptoms</b> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Night sweats <input type="checkbox"/> Wheezing
<b>HEENT Symptoms</b> <input type="checkbox"/> Headache <input type="checkbox"/> Eyesight problems <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Other head-related symptoms	<b>Cardiovascular Symptoms</b> <input type="checkbox"/> Chest pain or discomfort <input type="checkbox"/> Fast heart rate <input type="checkbox"/> Palpitations <input type="checkbox"/> Other cardiovascular symptoms
<b>Neck Symptoms</b> <input type="checkbox"/> Neck pain <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Lump or swelling in the neck <input type="checkbox"/> Other neck symptoms	<b>Gastrointestinal Symptoms</b> <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea
<b>Genitourinary Symptoms</b> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty/pain with urination <input type="checkbox"/> Increased urinary frequency	<b>Hematological Symptoms</b> <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising
<b>Skin Symptoms</b> <input type="checkbox"/> Itching <input type="checkbox"/> Skin lesions <input type="checkbox"/> Rashes <input type="checkbox"/> Other skin symptoms	<b>Psychological Symptoms</b> <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety
<b>Other symptoms:</b> <hr/> <hr/>	<b>Endocrine Symptoms</b> <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Other



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Dementia  
Epilepsy  
Headaches  
Medical Retina  
Multiple Sclerosis  
Neurology  
Neuro-Ophthalmology  
Parkinson's Disease  
Retinopathy  
Sleep Disorders

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Marital status:  Single  Married  Widowed  Other

Pharmacy: \_\_\_\_\_ Race: \_\_\_\_\_

Personal E-mail: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you: \_\_\_\_\_ Family Dr: \_\_\_\_\_

Name of spouse/next of kin that we may contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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**PROCEDURES****PERFORMED:**

Botox Injection  
Deep Brain  
Stimulator (DBS)  
EEG & Video EEG  
EMG & NCV  
Independent  
Medical Exams  
Retina Injections  
Retinal Laser  
Treatment  
Sleep Studies  
Vagal Nerve  
Stimulator (VNS)

**INSURANCE INFORMATION:**

(Patient is responsible for completion of insurance information below.)

Is today's visit the result of a motor vehicle accident?  Yes  No: Date of injury: \_\_\_\_\_

Is today's visit the result of a personal injury?  Yes  No: Date of injury: \_\_\_\_\_

Is today's visit the result of a work injury?  Yes  No Date of Injury: \_\_\_\_\_ Claim # \_\_\_\_\_

**Primary Ins.** \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Ins Address: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Secondary Ins:** \_\_\_\_\_ Phone: \_\_\_\_\_

Secondary Ins Address: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

**DISCLOSURE:**

I authorize the following means to communicate my health and/or account information:

Persons: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ Phone: \_\_\_\_\_

Voicemail messages can be left at: (\_\_\_\_\_) \_\_\_\_\_

E-mails may be sent to the address on file, or \_\_\_\_\_

\_\_\_\_\_  
Patient (or representative) Signature Date

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES:**

I have seen and understand the Burlington Neurology & Sleep Clinic, PLC’s Notice of Privacy Practices.

**ASSIGNMENT AND RELEASE:**

I, the undersigned, certify that I or my dependent assign directly to Burlington Neurology & Sleep Clinic, PLC and Dr. Dhuna, Dr. Raval, Dr. Pavuluri, Kelley Dawley and Mary Catherine Bentler , all insurance benefits, if any, otherwise payable to me for services rendered. As a courtesy, Burlington Neurology & Sleep Clinic, PLC will bill my insurance, and it is my responsibility to ensure timely payment. Acceptance of my insurance card in no way constitutes the clinic’s participation with my carrier. I understand that it is my responsibility to verify insurance coverage, eligibility and participation of this clinic and/or its doctors with my insurance carrier. I also understand that I am financial responsible for all charges whether paid or not by insurance, plus any finance charges which accrue at 18% annually on the balance not paid within 30 days of the statement date. There will be a charge of \$15.00 for all returned checks. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and communications.

**I acknowledge that failure to sign this form does not release me from financial responsibility, as outlined below, for services I receive from this clinic and its physicians.**

**CONTINUITY OF CARE:**

I give my permission to Burlington Neurology & Sleep Clinic, PLC to release my records for the continuity of my care and/or to refer me for further treatment.

**I, the undersigned, have read and understand the above information.**

\_\_\_\_\_  
Patient (or representative) Signature Date

**MEDICARE AUTHORIZATION:**

I request that payment of authorized Medicare or Medicare Advantage (any plan) benefits be made either to me or on my behalf to Anil Dhuna, M.D., Jugal Raval, M.D., Spriha Pavuluri, M.D., Mary Catherine Bentler, PA-C, Kelley Dawley, ARNP, Burlington, IA, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 on the CMS-1500 form, or else on other approved claim forms or electrically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charges and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. I authorize the use of this signature on all insurance submissions, including Medicare and all of my secondary insurances.

\_\_\_\_\_  
Beneficiary Signature Date