NEUROLOGY & SLEEP CLINIC PLC.

Office Use Only
☐ New Patient
☐ EMG/NCV
☐ Disability Exam

Dictation Done : _____

TREATMENT OF:
Alzheimers
Chronic Migraines
Epilepsy
Headaches
Memory Disorders
Multiple Sclerosis
Neuropathy
Parkinson's disease
Sleep Disorders
Stroke

PROCEDURES PERFORMED:
Botox Injection
Deep Brain Stimulator (DBS)
EEG & Video EEG
EMG & NCV
Independent Medical Exams
Rehab
Sleep Studies
Vagal Nerve Stimulator (VNS)

New Patient Intake Form

Anil Dhuna, M.D., F.A.A.S.M., F.A.A.N.
Spriha Pavuluri, M.D.
Kelley Dawley, ARNP
Becky Zwanziger, ARNP
Mikhail Shkiryak, 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?

_____ _____

_____ _____

_____

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More Info at www.NeurologyandSleepClinic.com

PAST MEDICAL HISTORY:
Do you have or have you had these medical conditions:

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

Other: _____

_____

PREVIOUS OPERATIONS:

____	Carotid artery surgery	____	Hysterectomy
____	Heart Valve replacement	____	Appendectomy
____	Carpal tunnel release	____	Back Surgery
____	Knee replacement	____	Brain surgery
____	Hip Replacement	____	Tonsillectomy
____	Gall bladder removal	____	Pacemaker

Other surgery:

_____

_____

SLEEP HISTORY:

Have you ever been diagnosed with Sleep Apnea? ____ Yes ____ No

If yes, what is your current treatment? ____CPAP ____Bi-Pap ____ Oral Appliance

Do you snore loudly? ____ Yes ____ No

Do you often feel tired, fatigued, or sleepy during the daytime? ____Yes ____No

Has anyone observed you stop breathing during your sleep? ____Yes ____No

Do you have or are you being treated for high blood pressure? ____ Yes ____No

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

REVIEW OF SYSTEMS: (CURRENT COMPLAINTS)

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

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Date: _____ Acct #:_____

Name: _____ SS#: _____

Address:_____

City: _____ State: _____ Zip: _____

Sex: [ ] M [ ] F Age: _____ Birthdate: _____

Marital status: [ ] Single [ ] Married [ ] Widowed [ ] Other

Pharmacy: _____ Race: _____

Durable Medical Equipment Supplier:_____

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: _____

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. Pavuluri, Kelley Dawley and Mikhail Shkiryak, and Becky Zwanziger, 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., Spriha Pavuluri, M.D., Kelley Dawley, ARNP, Becky Zwanziger, ARNP, Mikhail Shkiryak, 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

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EPWORTH SLEEPINESS SCALE

How likely are you to actually doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3= high chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (movie or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____