



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: _____

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)

Systemic Symptoms <input type="checkbox"/> Weight Change <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Other constitutional	Pulmonary Symptoms <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
HEENT Symptoms <input type="checkbox"/> Headache <input type="checkbox"/> Eyesight problems <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Other head-related symptoms	Cardiovascular Symptoms <input type="checkbox"/> Chest pain or discomfort <input type="checkbox"/> Fast heart rate <input type="checkbox"/> Palpitations <input type="checkbox"/> Other cardiovascular symptoms
Neck Symptoms <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	Gastrointestinal Symptoms <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
Genitourinary Symptoms <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty/pain with urination <input type="checkbox"/> Increased urinary frequency	Hematological Symptoms <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising
Skin Symptoms <input type="checkbox"/> Itching <input type="checkbox"/> Skin lesions <input type="checkbox"/> Rashes <input type="checkbox"/> Other skin symptoms	Psychological Symptoms <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety
Other symptoms: <hr/> <hr/>	Endocrine Symptoms <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Other



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TREATMENT OF:

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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Kelley Dawley, ARNP

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