



# NEUROLOGY & SLEEP CLINIC PLC.

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## New Patient Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

Referring Physician: \_\_\_\_\_ Date symptoms began: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

Briefly describe your present symptoms (problems): \_\_\_\_\_  
\_\_\_\_\_

Advanced Directive (DNR/Living Will/POA): \_\_\_\_\_

Any Recent Falls \_\_\_\_\_ Yes \_\_\_\_\_ No

Staff Use ONLY:

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP: \_\_\_\_\_

### **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"/> Diabetic Retinopathy    |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Tremor                  |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Autoimmune disease      |
| <input type="checkbox"/> CHF                 | <input type="checkbox"/> Osteoarthritis          |
| <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Anxiety disorder        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Migraine/headache       |
| <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> COPD                | <input type="checkbox"/> Stroke syndrome         |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Peripheral Neuropathy   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Dementia                |
| <input type="checkbox"/> GI Disorder         | <input type="checkbox"/> Restless Legs Syndrome  |
| <input type="checkbox"/> Kidney disorder     | <input type="checkbox"/> Obstructive sleep apnea |

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:

\_\_\_\_\_  
\_\_\_\_\_

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

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**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.

**FAMILY HISTORY:**

Please check if a member of your family has been diagnosed with:

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

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

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

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## **PATIENT REGISTRATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  M  F      Age: \_\_\_\_\_      Birth date: \_\_\_\_\_

Marital status:  Single  Married  Widowed  Divorced

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

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

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

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

POA (Power of Attorney): \_\_\_\_\_ Phone: \_\_\_\_\_

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 #: \_\_\_\_\_



NEUROLOGY &  
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Patient Number \_\_\_\_\_



**DISCLOSURE:**

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

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

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

Voicemail and/or text 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 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 \$25.00 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 BN&SC, PLC and all its providers, 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 (policy holder) Signature

\_\_\_\_\_  
Date



## Consent to Participate in Telemedicine Services

Telemedicine allows health care providers to evaluate, diagnose and treat patients at a distance using telecommunications technology. It requires sharing information to help improve your health care.

This information may be used for diagnosis, therapy, follow-up or education, scheduling, and billing purposes. It may include:

- Details of your medical history, examinations, and diagnostic test results. These may be communicated by the use of interactive video, audio, and telecommunication technology.
- You may receive a physical examination from onsite staff at your visit.
- Video, audio and/or photo recordings may be taken of you during the telemedicine visit and stored in your electronic medical record.
- A technical specialist may be present if needed for communication services.
- Individuals involved will be announced and are expected to maintain confidentiality or information obtained or observed.

### Expected benefits

- Improved access to medical care by enabling you to remain at your local health care site (your home, for example) while the health care provider collects and reviews test results at another site, which may be in another state
- More efficient evaluation and management for your medical needs
- Obtaining the expertise of a specialist without having to travel

### Possible risks

As with any medical procedure, there are possible risks associated with the use of telemedicine. These risks may include, but are not limited to:

- Medical evaluation or treatment may be delayed because of failure of equipment or technical services.
- The provider may decide the transmitted information is of poor quality, requiring the telemedicine visit to be rescheduled or a face-to-face visit with your local provider be scheduled.
- Security processes could fail, causing a breach in the security of personal information.
- Not having access to your complete medical record may result in adverse drug interactions, allergic reactions or other errors.

I understand my participation in telemedicine is voluntary. I may refuse to participate or decide to end my participation at any time. I understand that my refusal to participate, or my decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of withdrawing my consent to participate in telemedicine services.

I understand providers at the remote site and the local site may have access to relevant clinical information including mental health information, and alcohol and drug abuse information.

I understand Neurology & Sleep Clinic, PLC will use electronic systems that include network and software security protocols to protect my personal health information.

I have read this document and received information about the process and telemedicine providers. I hereby consent to participate in services using telemedicine under the terms described above. I understand this document will become a part of my medical record.





## Consent to Participate in Telemedicine Services

Please check the appropriate box:

\_\_\_\_ I want to participate in and receive services through telemedicine.

\_\_\_\_ I do not want to participate in telemedicine sessions, and I understand the consequences.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

- It has been determined the patient is unable to sign and, with attempt made, a legal guardian or personal representative is not available or accessible.
- It has been determined the patient is medically unable to give informed consent and a legal guardian or personal representative is available. Please complete:

The above consent is accepted and given on behalf of \_\_\_\_\_  
because it has been determined the patient is medically unable to give informed consent.

\_\_\_\_\_  
Legal guardian or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

Check if applicable:       telephone/verbal consent (witnessed by two staff members)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date