Plano Neurology, P.A.

4601 Old Shepard Place
Bldg 4, Suite 406
Plano TX 750935279
972-867-3535 FAX: 972-867-3530
Web: www.planoneurology.net

Geeta Rajan, M.D.

PATIENT INFORMATION

Chart Number _____

Primary Care Doctor/Referred by: _____

Patient Name: _____ Social Sec No: _____
Last First M.I.

Height ___ ft____ in Weight _____ lbs

Race: _____ Ethnicity: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Age: ____ Sex: M F Marital Status: M S D W

Spouse Name: _____ Spouse Phone Number: _____

Nearest Relative Not Living With You: _____

Relationship: _____ Phone Number: _____

Address: _____ City: _____ State/Zip: _____

PATIENT EMPLOYER INFORMATION

Employer:_____

City: _____ State:_____ Zip:_____ Phone:_____

GUARANTOR INFORMATION (Party responsible for payment)

Same as Above? Yes No Patient's Relationship to Guarantor:_____

Name:_____ Social Security Number:_____

Address:_____ City:_____ State/Zip:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Age:_____ Sex: M F

Employer:_____ Address:_____

Phone Number:_____ City:_____ State/Zip:_____

INSURANCE INFORMATION

Primary Insurance: HMO PPO POS MEDICARE MEDICAID WC OTHER_____

Name of Insurance Company: _____

If Medicare, are you setup for automatic crossover? Yes No

Member ID _____ Group ID _____

Secondary Insurance: HMO PPO POS MEDICARE MEDICAID WC OTHER_____

Name of Insurance Company: _____

Member ID _____ Group ID _____

PHARMACY INFORMATION

Pharmacy Name:_____ Pharmacy Number_____

Address_____

NEW PATIENT REGISTRATION DISCLOSURE FORM

PATIENT NAME:_____ Date:_____

DEAR PATIENT: In order for us to handle the increasing request for information concerning your medical care, progress, and medical history, it is necessary for us to obtain your permission in advance, to transmit such information. **Thank you for your assistance.**

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

I hereby authorize Plano Neurology, P.A. and its employees to release any information acquired in the course of my examination or treatment to insurance carriers, self-insurance plans, third party administrators, case managers, attorneys, employers, and healthcare providers as requested.

I hereby authorize Plano Neurology, P.A. and its employees to leave messages on my home voice-mail or answering machine in reference to all test or lab results.

ASSIGNMENTS OF BENEFITS AND AGREEMENT TO PAY

I hereby authorize Plano Neurology, P.A. to release my medical information pertaining to the diagnosis and/or treatment, including but not limited to, information concerning communicable diseases such as Human Immune Deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), drug and alcohol history, dental health, sexually transmitted diseases, laboratory test results, medical history, treatment or any other needed information necessary to file a health insurance claim form, or to obtain payment for your services. And, I hereby authorize and assign all medical benefits to which I am entitled relating to fees for your services, including Medicare and other government sponsored services, private insurance, group insurance, and any health benefits to Plano Neurology, P.A.

I acknowledge and understand that I am responsible for all the charges for all the services rendered to me. I agree to pay out-of-pocket deductibles, and/or co-pays, and/or non-covered services as may be required under my health insurance plan including services not covered by Medicare when I receive treatment.

If I do not have insurance coverage, I agree to pay my account in full or make arrangements for prompt payment by signing a payment agreement for the outstanding balance. Plano Neurology, P.A. accepts major credit cards and Personal Checks.

I understand that any check returned due to insufficient fund will incur a fee of $25.

I understand that I will be confirming my appointment a day before my appointment and failure to do so may result in the cancellation of my appointment. I understand that I may be assessed a fee of $50 if I do not show up for my appointment after confirmation or repeated cancellations or reschedules without at least twenty four hours notice.

_____

PRINT PATIENT'S OR MINOR'S NAME

_____

SIGNATURE OF PATIENT OR GUARDIAN DATE RELATIONSHIP

_____

WITNESS DATE

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Permission to view External Source Prescription History

In order to provide effective patient care, the physician may have to view patient prescription history from external sources such as pharmacy. Would you like to give permission to view prescription history?

☐ Grant Permission

☐ Deny Permission

_____
Name of Patient

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Personal Representative (if applicable)

_____
Description of Personal Representative's Authority

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I have received a copy of this document.

_____
Name of Patient

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Personal Representative (if applicable)

_____
Description of Personal Representative's Authority

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No Show / Cancellation Policy

We would like to inform you of our new policy due to a large volume of no shows and last minute cancellations. We are having to enforce a no show/cancellation policy to accommodate other patients who are awaiting appointments that require urgent attention.

Prior to your appointment we give courtesy calls to remind you of your appointment and give ample time for the appointment to be confirmed. Our courtesy calls are done within 48 hours prior to your appointment. If there is a cancellation for any reason we would like 24 hour notice. In the event 24 hour notice is not given, a last minute cancellation, or a no call / no show will result in a $50.00 charge to you.

We thank you for your understanding.

CHOOSE ONE OPTION

☐ I will call within 24 hours

☐ I will NOT call, but I will show up

☐ If I do not call within 24 hours, cancel my appointment

_____
Name of Patient

_____
Signature of Patient or Personal Representative

_____
Date

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Patient History

Date:

Name: Age: Sex:

Referring Physician:

Hand Dominance: ☐ Right ☐ Left ☐ Both

Present illness for which you are being seen today: _____
_____
_____
_____
_____
_____
_____

Past Medical History (√ where appropriate)

General History

- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Diabetes _____
- ☐ Respiratory Problems _____
- ☐ Kidney Problems _____
- ☐ Gastrointestinal Problem _____
- ☐ Inherited Disease _____
- ☐ Skin Disease _____
- ☐ Vision ENT Problem _____
- ☐ Arthritis _____
- ☐ Anxiety Depression _____
- ☐ Surgeries _____
- ☐ Bowel Bladder Problems _____
- ☐ HIV Positive _____
- ☐ Hepatitis (a,b,c,non-a,non-b) _____
- ☐ Other _____

Neurological History

- ☐ Headache _____
- ☐ Stroke _____
- ☐ Seizures _____
- ☐ Parkinson's Disease _____
- ☐ Multiple Sclerosis _____
- ☐ Neck/Back Pain _____
- ☐ Memory Problems _____
- ☐ Aneurysm _____
- ☐ Other _____

Medication and Allergies: Please see the additional sheet

Family Medical History

_____
_____
_____
_____

Social History

Single ☐ Married ☐ Children _____
Smoke ☐ Yes ☐ No Number of Years ____
Drink ☐ Yes ☐ No
Street Drugs _____

Current Occupation_____

Plano Neurology, P.A.

Medication List

(*Please include all OTC and Vitamins*)

Patient Name: Date Of Service:

Medication	**Strength**	**Frequency per day (circle one)**	**Quantity**
Example: Zoloft	50 mg	1 2 ③ 4	1 tab
Example: Fish oil	500IU	**1** **②** **3** **4**	2 tab am, 1 tab pm
		1 2 3 4	
		1 2 3 4	
		1 2 3 4	
		1 2 3 4	
		1 2 3 4	
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		1 2 3 4	
		1 2 3 4	

ALLERGIES:

Penicillin ☐	**Sulfa ☐**	**Codeine ☐**