MRN: _____

FLORIDA NEUROLOGY, P.A.

Sam Shanmugham, MD ◦ Elias Gizaw, MD ◦ Nitesh Shekhadia, MD ◦ Ramit Panara, MD ◦ Robert Rahe, PA-C

Lake Mary	Orange City	Tavares
755 Stirling Center Place Lake Mary, FL 32746 (407) 333-1718	2445 South Volusia Avenue Unit C-3 Orange City, FL 32763 (386) 218-6867	2710 Dora Avenue Tavares, FL 32778 (352) 508-5076

DATE: _____ /_____ /_____ **GENDER:** **MALE** _____ **FEMALE** _____

NAME: _____

DATE OF BIRTH: _____ /_____ /_____ **SOCIAL SECURITY #:** _____-_____-_____

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE: (_____) _____ - _____ **CELL PHONE:** (_____) _____ - _____

E-MAIL ADDRESS: _____@_____

(This information will not be disseminated to any third-parties.)

FLORIDA NEUROLOGY PROVIDER: _____

IS THIS THE OFFICE LOCATION THAT YOU ARE USUALLY SEEN IN? **YES**_____ **NO**_____

If not, at which of our office locations do you usually schedule your appointments?

Lake Mary_____ Orange City_____ Tavares_____

MRN: _____

MARITAL STATUS:

SINGLE_____ **MARRIED**_____ **PARTNERED**_____ **DIVORCED**_____

SEPERATED_____ **WIDOWED**_____

NAME OF REFERRING PHYSICIAN: _____

OFFICE PHONE: (_____) _____-_____ **FAX:** (_____) _____-_____

NAME OF PRIMARY CARE PHYSICIAN: _____

OFFICE PHONE: (_____) _____-_____ **FAX:** (_____) _____-_____

EMPLOYED: **YES**_____ **NO**_____ **RETIRED**_____

EMPLOYER'S NAME: _____

WORK PHONE: (_____) _____-_____

PRIMARY INSURANCE

INSURANCE COMPANY: _____

MEMBER ID: _____ **GROUP NUMBER:** _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

MEMBER ID: _____ **GROUP NUMBER:** _____

IF YOU ARE NOT THE POLICY HOLDER PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF POLICY HOLDER: _____

RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____ /_____ /_____ **SOCIAL SECURITY #:** _____-_____-_____

POLICY HOLDER'S EMPLOYER: _____

POLICY HOLDER'S MAILING ADDRESS: _____

MRN: _____

 **Please provide all pharmacy information. Prescriptions will be submitted electronically.**

PHARMACY NAME: _____

PHARMACY PHONE: (_____) _____ - _____

PHARMACY ADDRESS: _____

RACE / ETHNICITY:

Asian_____ **African American**_____ **Caucasian**_____

Hawaiian/Pacific Islander_____ **Native American/Alaskan**_____

Hispanic_____ **Prefer Not to Answer**_____ **Other**_____

LANGUAGE(S) SPOKEN: _____

- **IS THIS VISIT RELATED TO AN AUTO ACCIDENT? YES**_____ **NO**_____
- **IS THIS VISIT RELATED TO A WORKERS COMPENSATION CLAIM? YES**_____ **NO**_____

FLORIDA NEUROLOGY DOES NOT FILE WITH AUTO, HOME, OR ACCIDENT INSURANCE. WE ALSO DO NOT FILE WITH ANY WORKER'S COMPENSATION.

- **IN CASE OF AN EMERGENCY PLEASE CONTACT:**

NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE: (_____) _____ - _____ **ALTERNATE PHONE:** (_____) _____ - _____

ALTERNATE CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE: (_____) _____ - _____ **ALTERNATE PHONE:** (_____) _____ - _____

MRN: _____

CONFIDENTIAL COMMUNICATION

PLEASE ADVISE US ON YOUR PREFFERED METHOD OF CONTACT:

Home_____ **Work**_____ **Cell**_____ **Mail**_____ **E-Mail**_____

Okay to leave message with details_____ **Leave message with call-back number only**_____

- **IF YOU WISH TO RELEASE YOUR CONFIDENTIAL INFORMATION TO SOMEONE ELSE, SUCH AS A SIGNIFICANT OTHER, PLEASE INDICATE BELOW. ONLY THE PERSON NAMED BELOW WILL BE PERMITED TO HAVE ACCESS TO ANY WRITTEN OR VERBAL INFORMATION. THIS AUTHORIZATION IS VALID FOR ONE (1) CALENDAR YEAR.** (This release does not refer to your primary care and/or your referring physician.)

NAME: _____

RELATIONSHIP TO PATIENT: _____

PATIENT SIGNATURE: _____

DATE: _____ /_____ /_____

MRN: _____

REASON FOR VISIT: _____

DO YOU CURRENTLY OR HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?
(Check all that apply.)

O Alzheimer's / Dementia
O Anemia
O Angina
O Anxiety
O Arthritis
O Asthma
O Attention Deficit Disorder
O Bi-Polar Disorder
O Cancer: _____
O Congestive Heart Disease
O Coronary Artery Disease
O Depression
O Diabetes Mellitus
O DVT
O Gout
O Heart Disease
O Hernia
O High Blood Pressure
O High Cholesterol
O Hyperthyroid
O Hypothyroid
O Incontinence
O Loss of Balance
O Lung Disease
O Migraines / Headaches
O Multiple Sclerosis
O Muscular Dystrophy
O Night Sweats
O Pacemaker/Defibrillator
O Parkinson's Disease
O Prostate Cancer
O Rheumatoid Arthritis
O Seizures
O Sleep Disorders
O Stroke
O TIA
O Vertigo
O Weight Loss
O Other Medical Conditions Not Listed: _____

_____

_____

Alcohol Use: O Current O Past O Never

Please describe: _____

Tobacco Use: O Current O Past O Never

Please describe: _____

Substance Abuse: O Current O Past O Never

Please describe: _____

MRN: _____

Please list ALL PREVIOUS Surgeries: **DATE:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

CONDITION: **FAMILY MEMBER:** (Mother, Father, Brother, etc.)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:

Please indicate dosage and directions, and also include OTC medications, herbs, vitamins, and supplements.

O **Not taking any prescription or OTC medications**

O **List Attached (please provide a copy to keep for our records)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

MRN: _____

PLEASE LIST ALL MEDICATION ALLERGIES:

O **No Known Drug Allergies** O **List Attached (please provide a copy to keep for our records)**

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Please list ALL physicians associated with your care:

Physician's Name:	**Specialty:** (Ex: Cardio, Urology)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

MRN: _____

FINANCIAL AGREEMENT

READ AND INITIAL ALL ARROWS

_____ I AUTHORIZE FLORIDA NEUROLOGY, P.A. TO RELEASE MEDICAL INFORMATION TO MY INSURANCE CARRIER FOR PAYMENT OF SERVICES PROVIDED. I AUTHORIZE PAYMENTS FOR SUCH SERVICES BE MADE DIRECTLY TO FLORIDA NEUROLOGY, P.A.

_____ I AGREE THAT IN THE EVENT MY INSURANCE CARRIER DOES NOT PAY FOR THE MEDICAL SERVICES PROVIDED THAT I AM FULLY RESPONSIBLE FOR PAYMENT FOR ANY SUCH SERVICES.

_____ IF I MISS AN APPOINTMENT AND DO NOT GIVE OUR OFFICE A MINIMUM OF 48 HOURS ADVANCE NOTICE, I AGREE TO PAY A FEE OF **$60.00** FOR AN OFFICE VISIT AND **$80.00** FOR ANY OTHER SCHEDULED PROCEDURES.

_____ I AGREE, FOR ANY SERVICE PROVIDED BY FLORIDA NEUROLOGY, P.A., TO BE TURNED OVER TO A COLLECTION AGENCY FOR NON-PAYMENT. I AM RESPONSIBLE FOR THE FULL AMOUNT INCLUDING ANY ADDITIONAL FEES INCURRED TO FLORIDA NEUROLOGY, P.A ONCE MY ACCOUNT IS DEEMED IN COLLECTIONS.

_____ I AGREE TO PAY ALL CO-PAYS, COINSURANCE, DEDUCTIBLES, SHARE-OF-COST, OR ANY OTHER SUCH CHARGES AT THE TIME OF MY APPOINTMENT OR BEFORE ANY SERVICES ARE RENDERED.

By signing your name below, you are acknowledging that you have read and fully understand the information contained herein, and therefore agree to the terms of this financial agreement.

_____ _____

PATIENT / GUARANTOR SIGNATURE DATE

_____ _____

PRINT PATIENT / GUARANTOR NAME DATE

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT OUR BILLING DEPARTMENT AT (407) 333-1718

MRN: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

_____ _____ / _____ / _____

Print Patient's First & Last Name Date of Birth

Person / Organization Authorized to Disclose Information:	**Person / Organization Authorized to Receive Information:**
Name/Organization:	Name/Organization: Florida Neurology, P.A.
Address:	Address: 755 Stirling Center Place
City , State, & Zip Code:	City , State, & Zip Code: Lake Mary, Florida 32746
Phone #:	Phone #: 407-333-1718
Fax #:	Fax #: 407-333-1633

For the purpose of: O Legal Request O Moving out of Area O New Local Physician

O Other: _____

DATE(S) OF SERVICE: _____

This authorization will expire on the following date, event or condition*:_____

*If you fail to specify an expiration event or condition, this authorization will expire one (1) calendar year from signature date.

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I further understand that Florida Neurology, P.A. may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be released or reviewed:

O Complete Record
O All Diagnostic Test Results
O Pathology / Operative Report(s)
O Radiology Only
O Abstract Record
O Consult / Progress Notes
O Other please specify: _____

O Lab Only
O Genetic Counseling / Testing Information
O Mental Health
O HIV Testing
O Drug and / or Alcohol
O AIDS Information

_____ _____

Signature of Patient/Guardian **Date of Authorization**

_____

Print Name of Patient/Guardian