Associated Neurological Specialties and Sleep Disorder Center

1180 Seton Parkway, Suite 300 ❖ Kyle, Texas 78640 ❖ p: (512) 551-0846 ❖ f: (512) 828-8785
4407 Bee Caves Road, Bldg. 3, Suite 301 ❖ Austin, Texas 78746 ❖ p: (512) 458-2600 ❖ f: (512) 454-2292
Neeraj Manchanda, MD Rani Das, MD

Patient Information:

Patient Name: _____ DOB: _____ Date: _____

Social Security #: _____ Email Address: _____

Ins. Company: _____ ID #:_____ GRP #:_____

Primary Care Physician: _____ Phone: (_____)_____

Referring Physician: _____ Phone: (_____)_____

Preferred Pharmacy Name: _____ Location: _____

Occupation: _____ If retired, last occupation:_____

Allergies: Please list all drug allergies you may have.

Drug Name	**Reaction**	**Severity** (Mild, Moderate, Severe, Fatal)

Medications: Please list all of you current medications and doses, prescription and non-prescription. If you already have a list prepared please provide this to the medical assistant.

Medication Name	Dosage (mg)	Directions

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Family History: Please list all medical problems/conditions for relatives listed below.

Mother: _____

Father: _____

Brother(s): _____ _____

Sister(s): _____

Son(s): _____

Daughter(s): _____

Social History:

Do you smoke? ☐ Never ☐ Former Current: ☐ Daily ☐ Sometimes

Type: ☐ Cigarettes ☐ E-cigs ☐ Cigars ☐ Pipe ☐ Chewing Tobacco
per day: _____ Years used:_____ Quit Date:_____

Do you drink alcohol? ☐ Never ☐ Former Current: ☐ Daily ☐ Sometimes
per day: _____ Years used:_____ Quit Date:_____

Do you drink caffeinated beverages?: ☐ Yes ☐ No If yes, please indicate amount per day.
Coffee: _____/day Sodas:_____/day Tea:_____/day Energy Drinks:_____/day

Do you, or have you ever, used street drugs? ☐ Current ☐ In the past (Circle all that apply)

Never Analgesics Cocaine Crack Cocaine Heroin Marijuana Methamphetamine Narcotics

For Women Only:
Are you currently taking birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Is there a possibility you could be pregnant? ☐ Yes ☐ No
Are you trying to get pregnant? ☐ Yes ☐ No

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Surgical History: Have you ever undergone any of the following procedures? (Circle all that apply)

Abdominal Surgery
Appendectomy
Bladder Surgery
Breast Surgery
- ☐ Augmentation (Left-Right-Both)
- ☐ Biopsy (Left-Right-Both)
- ☐ Lumpectomy (Left-Right-Both)
- ☐ Mastectomy (Left-Right-Both)
- ☐ Reduction (Left-Right-Both)

Bilateral Tubal Ligation
Cardiac Surgery
- ☐ Cardiac Valve Replacement
- ☐ Carotid Endarterectomy
- ☐ Coronary Artery Bypass Graft
- ☐ Pacemaker
- ☐ Stent Placement
- ☐ Transplant

Cataract Surgery (Left-Right-Both)
Cesarean Section
Cholecystectomy (Gall Bladder Removal)
Colon Resection
Hernia Repair
Hip Surgery (Left-Right-Both)
Hysterectomy
Organ Transplant
Pancreatic Surgery
Shoulder Surgery (Left-Right-Both)
Splenectomy
Tonsillectomy
Other: _____
_____
_____
_____

Medical History: Do you have a history of any conditions listed below. (Circle all that apply)

Anemia	Diverticulitis	IBS
Aneurysm	Eating Disorder	Kidney Disease
Anxiety	Epilepsy	Liver Disease
Arrhythmia	Gout	Lung Disease
Asthma	Hay Fever	Migraines
Bipolar Disorder	Hearing Loss	Neuropathy
Coronary Disease	Heart Attack	Rheumatoid Arthritis
Cancer	Heart Disease	Seizure Disorder
COPD	Hepatitis: ☐ A ☐ B ☐ C	Sleep Apnea
Crohn's Disease	High Blood Pressure	Stroke
Degenerative Disc Disease	High Cholesterol	Tuberculosis
Depression	Hyperthyroidism	Other: _____
Diabetes	Hypothyroidism	_____

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND RECORD DISCLOSURE

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I understand that as part of my health care, Dr. Neeraj Manchanda/Dr. Rani Das originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, as well as plans my future care or treatment.

I understand that as part of Dr. Manchanda's/Dr. Das's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I certify that I understand the privacy risks of the mail, phone calls and email. I hereby authorize a representative or my physician to mail, call or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referrals, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Dr. Neeraj Manchanda/Dr. Rani Das in writing.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

I give permission to disclosure and discuss any information related to my medical condition(s) to/with the following family member(s) other relative(s) and/or close personal friend(s):

Name:_____Relationship:_____Phone#:_____
Name:_____Relationship:_____Phone#:_____
Name:_____Relationship:_____Phone#:_____
Name:_____Relationship:_____Phone#:_____

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.
I certify that I have received and read a copy of the Patient Information Privacy Policy and record disclosure.

Patient/Parent Signature: _____ Date:_____
Print Name:_____ Patient Date of Birth:_____

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Patient Authorizations

Our primary mission is to provide you with quality, cost effective medical care. It is important that we have a good understanding with our patient financial responsibility. We hope this summary will be helpful in explaining your responsibility and the expectations in maintaining a positive doctor patient relationship.

Please understand that financial responsibility for medical services rest between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitation on coverage that may be included in your plan.

- Co-payments and applicable deductibles are due at the time of service unless other arrangements have been made with our office.
- If you are uninsured, or if the services being provided are not covered by your insurance, you will be expected to provide payment in full at the time they are rendered.
- If you receive a payment from your insurance company in error, please bring in along with any paperwork to our office.

1. Authorization to Release Information:
I hereby authorize Dr. Neeraj Manchanda/Dr. Rani Das to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

2. Assignment of Insurance Benefits/Patient Financial Responsibility:
I hereby authorize direct payment of my insurance benefits to Dr. Neeraj Manchanda/Dr. Rani Das for services rendered to my dependents or me by Dr. Neeraj Manchanda's/Dr. Rani Das's providers or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Dr. Neeraj Manchanda/Dr. Rani Das is unable to collect from my insurance carrier for whatever reason.

3. Medicare/Medicaid/Insurance Benefits:
I request that payment from Medicare/Medicaid or any other insurance carrier, be made on my behalf to Dr. Neeraj Manchanda/Dr. Rani Das. I authorize the release of any of my or my dependent's records that these programs may request. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents or insurance company any information needed to determine these benefits payable for related services.

4. Lab/X-Ray/Diagnostic Services:
I understand that I may receive a separate bill if my medical care includes lab, x-ray or diagnostic services. I also understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

5. Consent to Treatment:
I hereby consent to evaluation, testing and treatment as directed by my physician.
Patient/Responsible Party Signature: _____
Date of Birth:_____Date:_____
Witness:_____Date:_____

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Epworth Sleepiness Scale

Name: _____ Date: _____

Use the following 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

It is important that you answer each question as best you can

Situation	Chance of Dozing
Sitting & Reading	
Watching TV	
Sitting, inactive in a public place (theater or meeting)	
Passenger in a car for about an hour with no break	
Lying down to rest in afternoon when circumstances permit	
Sitting quietly after lunch without alcohol	
In a car while stopped for a few minutes with traffic	