Associated Neurological Specialties & Sleep Disorder Center

4407 Beecave Road, Bldg 3, Suite 301 ◈ Austin, TX 78746 ◈ 512-458-2600 ◈ Fax 512-454-2292

1180 Seton Parkway, Suite 300 ◈ Kyle, TX 78640 ◈ 512-551-0846 ◈ Fax 512-828-8785

Neeraj Manchanda, MD Rani Das, MD

Section I **Patient Information** **Date: _____**

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip:_____

Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Email Address:_____

Date of Birth:_____ Sex: □Male □Female Social Security Number:_____

Check Appropriate Box: □Minor □Single □Married □Widowed □Separated □Divorced

Primary/Referring Physician Name:_____ Phone (_____)_____

Patient's Employer Name: _____ Phone (_____)_____

Person to contact in case of emergency:_____ Phone (_____)_____

Section II **Responsible Party**

Relationship to Patient: □Self □Spouse □Parent □Other: _____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Employer:_____ Work Phone: (____)_____ SSN#:_____

Section III **Insurance Information**

Name of Insured:_____DOB:_____Relationship to Patient:_____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City:_____State:_____Zip:_____

Insurance Company:_____ Grp #:_____ ID#:_____

Ins. Co. Address:_____ Ins. Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? □Yes □No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured:_____DOB:_____Relationship to Patient:_____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City:_____State:_____Zip:_____

Insurance Company:_____ Grp #:_____ID#:_____

Ins Co Address:_____ Ins Co. Phone:_____

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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.

Patient/Parent Signature: _____ Date:_____

Print Name:_____ Patient Date of Birth:_____

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:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

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.

Signature of Patient/Legal Guardian: _____Date:_____

(To be completed if patient refuses to sign acknowledgement)

Name of person providing notice: _____Date:_____

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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. We encourage you to ask questions if you do not understand any area.

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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Medical History:

Date: _____ My appointment is with: _____

Patient Name: _____ DOB: _____

Primary Care Physician (Name and Phone Number): _____

Reason for visit: _____

Previous Neurologist: _____

Please check the appropriate box: □ left-handed □ right-handed □ ambidextrous

Do you have a history of: (Circle all that apply and use the back of this page to explain, if necessary)

Anemia
Aneurysm
Anxiety
Arrhythmia
Asthma
BPH
Bipolar Disorder
Coronary Disease
Cancer: please give details on back
CHF
COPD
Crohn's Disease
CVA
Degenerative Disc Disease
Depression
Diabetes
Diverticulitis
Eating Disorder
Epilepsy
Gout
Hay Fever
Hearing Loss
Heart Attack
Heart Disease
Hepatitis: □A □B □C
High Blood Pressure
High Cholesterol
Hyperthyroidism
Hypothyroidism
IBS
Kidney Disease
Liver Disease
Lung Disease
Migraines
Multiple Sclerosis
Neuropathy
Rheumatoid Arthritis
Seizure Disorder
Sickle Cell Anemia
Sleep Apnea
Stroke
Tuberculosis
Other:_____
_____
_____
_____
_____
_____

Family History:

Does anybody in your family have a history of any of the problems listed above? If so, please explain.

Mother:_____

Father: _____

Brother(s): _____

Sister(s): _____

Children: _____

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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 (Left – Right – Both)
- □ Augmentation
- □ Biopsy
- □ Lumpectomy
- □ Mastectomy
- □ Reduction

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
Knee Surgery (Left – Right – Both)
Organ Transplant: please explain
Pancreatic Surgery
Shoulder Surgery (Left – Right – Both)
Splenectomy
Tonsillectomy
Other:_____
_____
_____
_____

Social History:

Occupation: _____ **If retired, last occupation:** _____

Last menstrual cycle: _____ **Do you use contraception?:** □ Yes □ No Type: _____

Are you currently breast-feeding?: □ Yes □ No

Do you drink caffeinated beverages? Y / N **If yes, please indicate amount per day.**

Coffee: _____/ Day Sodas: _____/ Day Tea: _____/ Day Energy Drink: _____/ Day

Do you use tobacco products?

Non-smoker Former smoker: _____ (length of use) _____/ Day _____(Quit Date)

Cigarettes: _____/ Day Cigar: _____/ Day Pipe: _____/ Day Chew: _____/ Day

Do you drink alcohol? (Circle one)

Never Rarely Socially Daily: _____/ Day Former Drinker

If former drinker, length of use: _____ Amount per day: _____ Quit Date: _____

Do you, or have you ever, used street drugs? (Circle all that apply)

Never Analgesics Cocaine Crack Cocaine Heroin Marijuana Methamphetamine Narcotics

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Medications:

Please list all of your current medications and doses, including prescription and over-the-counter. Use the back of this page if necessary. **If you have a medication list already prepared, please attach here.**

_____

_____

_____

_____

_____

_____

Allergies:

Please list any known allergies to medications and the associated reaction.

Drug	Reaction

Pharmacy:

Pharmacy Name (Ex: Walgreens): _____

Location (Ex: Kyle Parkway in Kyle, TX): _____

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Symptoms:

Please circle the symptoms that you currently have or have had in the last six months. If you do not have any of listed symptoms, please circle "No symptoms". If you have symptoms not listed, please explain in "Other symptoms" below.

General:

No symptoms
Fever
Chills
Weight loss
Weight gain
Fatigue
Fainting
Depression
Anxiety

Eyes/Ears:

No symptoms
Change in vision
Blurred vision
Double vision
Loss of hearing
Ringing in the ears
Earache (R – L – B)

Throat/Sinuses:

No symptoms
Sore throat
Nasal congestion
Sinus pain
Nose bleeds

Neck:

No symptoms
Neck stiffness
Swollen lymph nodes

Pulmonary:

No symptoms
Shortness of breath
Dry cough
Productive cough
Pneumonia

Cardiovascular:

No symptoms
Chest pain
Palpitations
Hypertension
Heart murmur

Vascular/Hematologic:

No symptoms
Swollen legs
Blood clots
Anemia
Easy bruising or bleeding
Transfusions

Musculoskeletal:

No symptoms
Muscle aches
Joint pains

Gastrointestinal:

No symptoms
Swallowing difficulty
Stomach pain
Constipation
Diarrhea
Hepatitis (A – B – C)

Urinary:

No symptoms
Frequency
Incontinence
Frequent infections

Neurological:

No symptoms
Headache
Seizure
Stroke
Weakness
Tremor
Imbalance
Falls

Immunologic:

No symptoms
Hay fever
HIV exposure
Persistent infections
Urticaria (hives)

Endocrine:

No symptoms
Cold intolerance
Heat intolerance
Excessive hunger
Excessive thirst
Excessive sweating
Excessive urination
Hot flashes
Steroid use
Weight change

Other Symptoms:

_____
_____
_____
_____
_____