PATIENT INFORMATION - PLEASE PRINT

Name _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work or Cell Phone _____

Social Security # _____ Birthdate _____

Sex Male/Female _____ Race _____

Marital Status _____ Spouse _____

Employer _____

Employer Address _____

Spouse's Employer _____ Phone # _____

Guarantor _____

Relation to Patient _____ Phone # _____

Their Employer _____ Phone # _____

Is your injury or illness due to an automobile accident or work-related injury? _____

If yes, date of injury _____

In emergency contact _____ Phone # _____

I, the undersigned, hereby acknowledge that it is the policy of this office that all payment be made at each visit and I am responsible for payment of all services for the above patient to the physician, rendered not covered by Medicare assignment, Medicaid, workman's compensation, or other benefits agreed by the provider of such services.

X _____ Date _____

I authorize release of any medical information necessary to process this claim to third party carriers and also certify that the information contained herein is correct.

X _____ Date _____

Referring Physician _____

Primary Insurance _____

Address _____ City _____ State _____ Zip _____

Phone number to Verify Coverage _____

Insured _____ Relation to Patient _____

Insured's Social Security # _____ / Insured's DOB _____

Through Employer? _____

Policy # _____ Group # _____

Secondary Insurance _____

Address _____ City _____ State _____ Zip _____

Phone Number to Verify Coverage _____

Insured _____ Relation to Patient _____

Insured's Society Security # _____

Through Employer? _____

Policy # _____ Group # _____

I authorize payment of medical benefits to the physician or supplier for services rendered.

X _____ Date _____

LIFETIME AUTHORIZATION - Medicare Patients Only

I request that payment of authorized Medicare benefits to be made to the physician or supplier for any services rendered to me. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services

X _____ Date _____

MEDICAL INFORMATION

NAME _____ AGE _____ TODAY'S DATE _____

REFERRING PHYSICIAN COMPLETE NAME _____ PHONE # _____

PRIMARY CARE PHYSICIAN COMPLETE NAME _____ PHONE # _____

PLEASE LIST THE SYMPTOMS FOR WHICH YOU ARE SEEING THE NEUROLOGIST TODAY:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

THIS BOX FOR PHYSICIAN USE ONLY:

PLEASE CHECK IF YOU HAVE ANY OF THE SYMPTOMS LISTED IN THE LAST 6 MONTHS.

Yes	No		Yes	No		Yes	No	
		PERSISTENT HA			DOUBLE VISION			SHORTNESS OF BREATH
		PERSISTENT NECK PAIN			DIFFICULTY SWALLOWING			CHEST WHEEZING
		CONFUSION			SLURRED SPEECH			CHEST PAIN
		MEMORY LOSS			HOARSENESS			PALPITATIONS
		PASSING OUT			RINGING EARS			DIARRHEA
		CONVULSIONS			DIZZINESS			ABDOMINAL PAIN
		TREMOR			LOSS OF HEARING			BLOOD IN STOOLS
		NUMBNESS/TINGLING			COORDINATION PROBLEMS			RASH
		LOSS OF SMELL			FALLS			BLOOD IN URINE
		LOSS OF TASTE			DIFFICULTY SLEEPING			URINARY URGENCY
		LOSS OF VISION			DEPRESSION			

IF APPLIES, ARE YOU PREGNANT? _____ PHYSICIAN'S SIGNATURE _____

HAVE REVIEWED YES & NO'S? _____

HAVE YOU HAD ANY RECENT TESTS OR X-RAYS (CT SCANS, MRI, EEG, ETC.)

TYPE OF TEST	DATE	WHERE
1)		
2)		
3)		
4)		

PAST MEDICAL HISTORY: PLEASE LIST YOUR MEDICAL ILLNESSES DIAGNOSED IN THE PAST:

	DATE OR AGE
1)	
2)	
3)	
4)	

SURGERIES IN THE PAST:	DATE OR AGE
1)	
2)	
3)	
4)	

CURRENT MEDICATIONS, PLEASE INCLUDE STRENGTH AND HOW MANY PER DAY

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

ALLERGIES/REACTION:

1) _____
2) _____
3) _____

PERMANENT PHARMACY AND PHONE NUMBER:

_____

_____

FAMILY HISTORY: DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE ONE OF THE FOLLOWING: PLEASE SPECIFY FATHER, MOTHER, ETC. . .

DIABETES _____

HEART DISEASE _____

HIGH BLOOD PRESSURE _____

STROKE _____

EPILEPSY/SEIZURES _____

THYROID DISEASE _____

ELEVATED CHOLESTEROL _____

MIGRAINE HEADACHES _____

OTHER ILLNESSES NOT LISTED ABOVE:

_____

_____

_____

SOCIAL HISTORY:

OCCUPATION _____

TOBACCO USE: TYPE _____ AMOUNT: _____ NUMBER OF YEARS: ____

ALCOHOL USE: TYPE _____ AMOUNT: _____ NUMBER OF YEARS: ____

ILLICIT

DRUG USE: TYPE _____ AMOUNT: _____ NUMBER OF YEARS: ____

DO YOU HAVE ANY BARRIERS TO LEARNING? _____ yes _____ no

(i.e. reading, writing or comprehension)

IF YES, PLEASE EXPLAIN: _____

_____

DO YOU HAVE ANY RELIGIOUS BELIEFS THAT WOULD WARRANT US TO TREAT YOU IN A SPECIAL MANNER?

_____ yes _____ no

IF YES, PLEASE EXPLAIN _____

_____

DO YOU HAVE AN ADVANCED DIRECTIVE? _____ yes _____ no

IF YES, MAY WE PLEASE HAVE A COPY? _____

DATE: _____ PHYSICIAN'S SIGNATURE: _____

NORTHWEST NEUROLOGY, PC

ADULT AND PEDIATRIC NEUROLOGY
COMPUTERIZED AXIAL TOMOGRAPHY
MAGNETIC RESONANCE IMAGING
CLINICAL POLYSOMNOGRAPHY

ROBERT G. BASHUK, M.D.
DANIELA GUILLIAM, M.D.
SANDY MCGAFFIGAN, M.D.
SABA BEJANISHVILI, M.D.
SITAL V. PATEL, M.D.

ELECTROENCEPHALOGRAPHY
EVOKED POTENTIALS
ELECTROMYOGRAPHY
BOTULINUM TOXIN

DIPLOMATE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

HIPPA Privacy Authorization Form

Date: _____

I, _____, give permission for Northwest Neurology, P.C. physicians and/or office staff to release or discuss my medical condition or any related information including, but not limited to, information contained in my medical record with the following person(s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This release of information will be effect until revoked by me in writing.

Patient Signature or Authorized Representative	Date of Birth	Date
_____	_____	_____

Witness Signature	Date
_____	_____

4460 Austell Road
Austell, Georgia 30106
Phone: (770) 941-4716 • Fax: (770) 941-3047

2520 Windy Hill Road
Suite 202
Marietta, Georgia 30067
Phone: (770) 952-0255 • Fax: (770) 952-0635

NORTHWEST NEUROLOGY
NO SHOW POLICY FOR IN-OFFICE TESTING

Dear Patient,

Due to the number of NO SHOW appointments for in-office testing we are updating our policy for missed appointments.

Please understand that we have technicians here in the office to perform your test. We set aside appointment times for each patient. We ask that you call at least 24 hours prior to the scheduled appointment so that we may provide other patients with an opportunity to take that appointment.

We understand that you may miss your appointment due to emergencies, so please contact our office so that we may reschedule your appointment and we can accommodate other patients in that time slot.

PLEASE BE INFORMED THAT THERE IS A **$100.00** MISSED APPOINTMENT FEE WHEN NO SHOWING FOR IN-OFFICE TESTING. THIS FEE HAS TO BE PAID IN FULL BEFORE YOU ARE RESCHEDULED FOR TESTING OR ARE SCHEDULED FOR AN APPOINTMENT WITH THE DR. THIS FEE IS NOT BILLED TO YOUR INSURANCE COMPANY.

Patient Name (Please print) _____

Patient/Caregiver/Guardian Signature _____

Date _____