

# NEUROLOGY & SLEEP CLINIC

KIRAN SHAH, MD

Board Certified in Neurology and Sleep Medicine

4217 Marsh Ridge Rd, Ste 120

Carrollton, TX 75010

www.thebrainmd.com

Phone: (972) 306 6300

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## REGISTRATION FORM

### Patient Information:

Patient (Last, First): \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_ Gender: \_\_\_\_\_

Ph # Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

DL#: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Parent's Name (if Patient is Minor): \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Name & Address of nearest relative (not living with you): \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

Referring Physician Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### Primary Insurance Company Information

Insurance Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Soc Sec #: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Medicare # (if Applicable): \_\_\_\_\_ Medicaid # (if applicable): \_\_\_\_\_

### Secondary Insurance Information

Is Patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

\_\_\_\_\_  
**Patient's or Guardian's Signature**

\_\_\_\_\_  
**Date**

**HISTORY FORM**

**Date:** \_\_\_\_\_ **Patient Name:** (Last, First) \_\_\_\_\_

Referring Physician's Name and Ph. #: \_\_\_\_\_

DOB: \_\_\_\_\_ S.S#: \_\_\_\_\_ Occupation: \_\_\_\_\_ Gender: M / F

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Neck Girth: \_\_\_\_\_ What hand do you write? Right or Left

**Chief Complaint:** Describe your present complaints: \_\_\_\_\_

Do you have any of the following complaints at present? (Check the box if present)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Headache                    | <input type="checkbox"/> Nausea/Vomiting       | <input type="checkbox"/> Falls                    |
| <input type="checkbox"/> Black out                   | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Hearing problems         |
| <input type="checkbox"/> Difficulty in vision        | <input type="checkbox"/> Difficulty in speech  | <input type="checkbox"/> Memory problems          |
| <input type="checkbox"/> Difficulty in passing urine | <input type="checkbox"/> Difficulty in walking | <input type="checkbox"/> Difficulty in swallowing |
| <input type="checkbox"/> Difficulty in using hands   | <input type="checkbox"/> Weakness              | <input type="checkbox"/> Numbness or tingling     |
| <input type="checkbox"/> Pain in any part of body    | <input type="checkbox"/> Sleep problems        | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Muscle atrophy              | <input type="checkbox"/> Tremor                | <input type="checkbox"/> High Blood pressure      |
| <input type="checkbox"/> Palpitation/Arrhythmia      | <input type="checkbox"/> High cholesterol      | <input type="checkbox"/> Heart Failure            |
| <input type="checkbox"/> Heart attack                | <input type="checkbox"/> COPD/Emphysema        | <input type="checkbox"/> Cough                    |
| <input type="checkbox"/> Sinus disease               | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Diarrhea                 |
| <input type="checkbox"/> Other: _____                |  |   |

For Women only: Mark Yes or No

\_\_\_ Do you have menstrual problems? \_\_\_ Are you taking birth control pills? \_\_\_ Are you pregnant?  
\_\_\_ Have you had a hysterectomy? \_\_\_ Are you planning on having children with in next year?

**Past History:**

Have you had any major medical problems? \_\_\_\_\_

Past Surgical History: Give name and date of any operations which you have had in the past?

Have you had any accidents or injuries in the past? \_\_\_\_\_

Have you been hospitalized recently? If yes, give details: \_\_\_\_\_

**Medications:** (include all sleep and over the counter medications, also note the frequency of medicines)

**Allergies:** (Medication & food) \_\_\_\_\_

**Family History:** Any hereditary condition that runs in the family?: \_\_\_\_\_

Are you adopted? Yes or No: \_\_\_\_\_

Do you know of any blood relative, who has had any of the following? Check the box if present

- |  |  |
|--|--|
| <input type="checkbox"/> Similar type of illness that you have now | <input type="checkbox"/> Alzheimer's                     |
| <input type="checkbox"/> Stroke                                    | <input type="checkbox"/> Cancer                          |
| <input type="checkbox"/> Migraines                                 | <input type="checkbox"/> Diabetes                        |
| <input type="checkbox"/> High Blood pressure                       | <input type="checkbox"/> Epilepsy                        |
| <input type="checkbox"/> Heart problems                            | <input type="checkbox"/> Depression or Nervous breakdown |
| <input type="checkbox"/> Parkinson's or Tremor                     | <input type="checkbox"/> Muscle or Nerve disease         |

Relation to patient	If alive (mention good /fair /poor health status)	Age	Cause if deceased
Father			
Mother			
Brothers/Sisters			
Children			

**Personal and Social History:**

Do you Smoke? \_\_\_\_\_ Since How Long? \_\_\_\_\_ Cigarettes \_\_\_ Cigars \_\_\_ How many per day? \_\_\_\_\_  
 Do you use alcohol? \_\_\_\_\_ What type? \_\_\_\_\_ How long? \_\_\_\_\_ How Much? \_\_\_\_\_  
 Caffeine Intake: (tea, coffee, soda) \_\_\_\_\_ How many per day? \_\_\_\_\_  
 Are you or have you ever been addicted to any drugs or alcohol? \_\_\_\_\_  
 Regular Exercise: \_\_\_\_\_ Who do you live with? \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Your level of education: \_\_\_\_\_ What is your job? \_\_\_\_\_ Your spouse's job? \_\_\_\_\_

**Review of system:** Have you had any of the following problems at present, if yes, check the box?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Fever/chills/night sweats     | <input type="checkbox"/> Weight loss or gain   | <input type="checkbox"/> Loss of vision or double vision |
| <input type="checkbox"/> Pain                          | <input type="checkbox"/> Weakness              | <input type="checkbox"/> Skin Rash                       |
| <input type="checkbox"/> Breast disease                | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Ear, mouth and throat disease   |
| <input type="checkbox"/> Neurological condition        | <input type="checkbox"/> Depression            | <input type="checkbox"/> Nervous breakdown               |
| <input type="checkbox"/> Chest pain                    | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Diabetes                        |
| <input type="checkbox"/> Thyroid disorder              | <input type="checkbox"/> Abdomen complaints    | <input type="checkbox"/> Bleeding/lymphatic disorder     |
| <input type="checkbox"/> Urinary complaints            | <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Sexual complaint                |
| <input type="checkbox"/> Allergic/Immunologic disorder | <input type="checkbox"/> Infectious disease    | <input type="checkbox"/> Other: _____                    |

**Sleep Environment:**

What time do you go to sleep on weekdays? \_\_\_\_\_  
 What time do you go to sleep on weekends? \_\_\_\_\_  
 Usual wake up time on weekdays? \_\_\_\_\_  
 Usual wake up time on weekends? \_\_\_\_\_  
 Average number of awakenings during night? \_\_\_\_\_  
 Do you read in bed? (Yes/No) \_\_\_\_\_  
 Do you carry work to bed? (Yes/No) \_\_\_\_\_  
 Do you watch TV from bed? (Yes/No) \_\_\_\_\_  
 Does your bed partner have sleep disorder? (Yes/No) \_\_\_\_\_  
 Do you nap during day time? If Yes, How long? (Yes/No) \_\_\_\_\_

**Sleep History:**

Please answer the following from a scale of 0 to 3.

0- not at all, 1- mild, 2- moderate, 3- severe

Do you have trouble falling asleep? _____	0	1	2	3
Do you have trouble remaining asleep? _____	0	1	2	3
Do you snore? _____	0	1	2	3
Does your breathing stop at night? _____	0	1	2	3
Do you have to pass urine at night? _____	0	1	2	3
Do you suffer from heartburns at night? _____	0	1	2	3
Do you kick your legs at night? _____	0	1	2	3
Do you have sweating at night? _____	0	1	2	3
Do you grind your teeth at night? _____	0	1	2	3
Do you experience an inability to move while falling asleep? _____	0	1	2	3
Do you see any unusual vision at sleep onset? _____	0	1	2	3
Do you feel groggy on awakening? _____	0	1	2	3
Do you suffer morning headaches? _____	0	1	2	3
Do you wake up with a dry mouth? _____	0	1	2	3
Do you have nightmares? _____	0	1	2	3
Have you suffered from a seizure in your sleep? _____	0	1	2	3
Are you sleepy during the daytime? _____	0	1	2	3
Do you feel fatigued during the daytime? _____	0	1	2	3
Do you have to fight sleep during driving? _____	0	1	2	3
Do you suffer from attacks of loss of strength when startled? _____	0	1	2	3
Do you suffer from memory problems? _____	0	1	2	3
Have you ever had a motor vehicle accident due to sleepiness? _____	0	1	2	3

**Epworth Sleepiness Scale:**

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations?

0 = Would never doze, 1 = Slight chance of dozing, 2 = Moderate chance of dozing, 3 = High chance of dozing

**SITUATION**

**CHANCE OF DOZING**

Sitting and Reading _____	0	1	2	3
Watching television _____	0	1	2	3
Sitting inactive in a public place (such as a theater) _____	0	1	2	3
As a car passenger (for an hour without a break) _____	0	1	2	3
Lying down to rest in the afternoon _____	0	1	2	3
Sitting and talking to someone _____	0	1	2	3
Sitting quietly after lunch without alcohol _____	0	1	2	3
In a car, while stopping for a few minutes in traffic _____	0	1	2	3

TOTAL SCORE: \_\_\_\_\_

I have reviewed and completed all 3 pages of History Form

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_\_  
Date

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Payment Policy:** I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits assigned. Neurology and Sleep Clinic, LLP files claims for Medicare assignment and only the managed care plans, which we are contracted. Claims will not be filed with other insurance carriers. If you plan to pay by check and it is dishonoured, a processing fee of \$25 will be assessed.

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_\_  
Date

**Assignment of Benefits:** I assign to the treating physician of Neurology and Sleep Clinic, LLP all payments for medical services rendered to my dependents or myself for services filed to insurance on my behalf.

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_\_  
Date

**Phone Call Message Consent:**

I authorize that messages may be left for the patient about appointment reminders and/or medical information regarding patient care:

At work \_\_\_\_\_ on home answering machine \_\_\_\_\_ with spouse or other family member \_\_\_\_\_  
Initial Initial Initial

Name of spouse \_\_\_\_\_ Name of family member(s) \_\_\_\_\_

On a cell phone \_\_\_\_\_ Number of cell phone \_\_\_\_\_  
Initial

I may revoke consent for any or all of the above initialled items at any time in writing. I certify that all information provided to Neurology and Sleep Clinic, LLP is correct.

**For Medicare Patients Only**

I authorize the treating physician of Neurology and Sleep Clinic to release medical information about me to the Social Security Administration and the Health Care Financing Administration (HCFA) or its intermediaries, or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Neurology and Sleep Clinic, LLP. Regulations pertaining to Medicare assignment of benefits apply.

I also authorize the same release of information to any Medicare supplemental insurance entities (i.e. Medigap) and further request payment of medical insurance benefits to the party who accepts assignment.

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_\_  
Date

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Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SSN: \_\_\_\_\_

## **Consent to Treatment:**

I hereby give my consent for medical treatment by the physicians or under the direction of the physicians of Neurology and Sleep Clinic.

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_\_  
Date

## **Release of Medical Records:**

I hereby authorize Kiran Shah, MD or Alpa Shah, MD (circle one) to send or obtain my medical information needed for my care.

I understand that the specific information to be released may include all physician records as well as treatment of drug or alcohol abuse, mental illness, or communicable disease; this does include Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). I also understand that this authorization may be revoked by the person giving authorization by written and dates notice, except to the extent that disclosure of information had been made prior.

You have the right to limit medical information we discuss to someone involved in your care, if you wish to do so, please write down any persons or facilities that you do not want to receive information and the information that you want limited. Please note that Neurology & Sleep Clinic does not have to agree to your request.

\_\_\_\_\_  
**Patient's or Guardian's Signature**

\_\_\_\_\_  
**Date**

Restriction List:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Authorization List:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

## Notice of Privacy Practices

I understand that as part of my healthcare, Neurology & Sleep Clinic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Neurology & Sleep Clinic's Notice of Privacy Policies provides specific information and a complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices and understand that Neurology & Sleep Clinic reserves the right to change the Notice of Privacy Practices. If changes are made to the Notice of Privacy Practices, they will be posted in the office where they can be seen, and I will have the opportunity to review the changes. I understand that I have the right to restrict the use/or disclosure of my personal health information for treatment, payment or healthcare operations and that Neurology & Sleep Clinic is not required to agree to the restriction requested. I may revoke this consent at any time in writing except to the extent that Neurology & Sleep Clinic has taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided access and have reviewed Neurology & Sleep Clinic Notice of Privacy.

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_\_  
Date

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## CONSENT FOR SLEEP STUDY

### A) CONSENT FOR TREATMENT

I acknowledge the need for medical care and hereby request and voluntarily consent to receive the usual medical services as well as the diagnostic procedures and medical treatment. I understand that there is no guarantee as to the outcome or results of the treatments or examinations received.

Signature of Patient: \_\_\_\_\_

### B) PATIENT INFORMATION

I have received information about my upcoming Sleep (polysomnography) Study. The potential diagnostic benefits of the study and the alternatives have been fully explained to me and I understand my options. I have received all of the information I wish and my questions have all been answered. I understand that I may refuse consent. **I GIVE MY INFORMED AND VOLUNTARY CONSENT** to the proposed diagnostic study, which will include:

1. Sensor application for measurement of sleep and breathing
2. Video recording to measure abnormal movements during sleep
3. Initiation of treatment for sleep disordered breathing

I understand that the alternatives to the proposed diagnostic study would be:

- a. To decline the study

Signature of Patient to proceed: \_\_\_\_\_

### C) PARENT/GUARDIAN CONSENT

I voluntarily give my authorization and consent to the performance of a Sleep (polysomnography) Study. By signing below, I state that I am at least 18 years old or serve as legal guardian for a minor or an adult that is not legally competent to consent.

Signature of Patient: \_\_\_\_\_

### D) CONFIDENTIALITY

I understand that any and all medical care that I receive at the office of Kiran P. Shah, MD, PA will be treated with the utmost confidentiality. However to facilitate my medical care I hereby authorize the office of Kiran P. Shah, MD, PA to provide information about my treatment and medical condition to the following.

Name/ relationship \_\_\_\_\_

Name/ relationship \_\_\_\_\_

**\*Please provide our office with 48 hours notice if you must cancel your test or you may be subject to a \$50.00 cancellation fee.**

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_