NEUROLOGY & SLEEP CLINIC

KIRAN SHAH, MD
Board Certified in Neurology and Sleep Medicine
4217 Marsh Ridge Rd, Ste 120
Carrollton, TX 75010
Phone: (972) 306 6300 **www.thebrainmd.com** **Fax: (972) 306 6500**

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)

☐Headache	☐Nausea/Vomiting	☐Falls
☐Black out	☐Dizziness	☐Hearing problems
☐Difficulty in vision	☐Difficulty in speech	☐Memory problems
☐Difficulty in passing urine	☐Difficulty in walking	☐Difficulty in swallowing
☐Difficulty in using hands	☐Weakness	☐Numbness or tingling
☐Pain in any part of body	☐Sleep problems	☐Seizures
☐Muscle atrophy	☐Tremor	☐High Blood pressure
☐Palpitation/Arrhythmia	☐High cholesterol	☐Heart Failure
☐Heart attack	☐COPD/Emphysema	☐Cough
☐Sinus disease	☐Constipation	☐Diarrhea
☐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

- ☐ Similar type of illness that you have now
- ☐ Stroke
- ☐ Migraines
- ☐ High Blood pressure
- ☐ Heart problems
- ☐ Parkinson's or Tremor
- ☐ Alzheimer's
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Depression or Nervous breakdown
- ☐ 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?

- ☐ Fever/chills/night sweats
- ☐ Pain
- ☐ Breast disease
- ☐ Neurological condition
- ☐ Chest pain
- ☐ Thyroid disorder
- ☐ Urinary complaints
- ☐ Allergic/Immunologic disorder
- ☐ Weight loss or gain
- ☐ Weakness
- ☐ Heart Disease
- ☐ Depression
- ☐ Shortness of breath
- ☐ Abdomen complaints
- ☐ Constipation/diarrhea
- ☐ Infectious disease
- ☐ Loss of vision or double vision
- ☐ Skin Rash
- ☐ Ear, mouth and throat disease
- ☐ Nervous breakdown
- ☐ Diabetes
- ☐ Bleeding/lymphatic disorder
- ☐ Sexual complaint
- ☐ 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**

NEUROLOGY & SLEEP CLINIC

KIRAN SHAH, MD
ALPA SHAH, MD
4217 Marsh Ridge Rd, Ste 120
Carrollton, TX 75010
Phone: (972) 306 6300 **www.thebrainmd.com** **Fax: (972) 306 6500**

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**

NEUROLOGY & SLEEP CLINIC

KIRAN SHAH, MD
ALPA SHAH, MD
4217 Marsh Ridge Rd, Ste 120
Carrollton, TX 75010
Phone: (972) 306 6300 **www.thebrainmd.com** **Fax: (972) 306 6500**

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:
_____

_____

_____

NEUROLOGY & SLEEP CLINIC

KIRAN SHAH, MD
ALPA SHAH, MD
4217 Marsh Ridge Rd, Ste 120
Carrollton, TX 75010
Phone: (972) 306 6300 **www.thebrainmd.com** **Fax: (972) 306 6500**

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**

NEUROLOGY & SLEEP CLINIC

KIRAN SHAH, MD
Board Certified in Neurology and Sleep Medicine
4217 Marsh Ridge Rd, Ste 120
Carrollton, TX 75010
Phone: (972) 306 6300 **www.thebrainmd.com** **Fax: (972) 306 6500**

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 MYINFORMED 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_____