NEUROLOGY NEURODIAGNOTIC LAB, LLC

NASROLIAH ESLAMI, M.D., BOARD CERTIFIED NEUROLOGIST

Please carefully answer the question below. This is confidential and will become a part of your medical record. Please print.

NAME:_______________________________________DOB:____________AGE:_______SEX:______

MEDICAL HISTORY:

Please list any major childhood illness:

____

Please list any medical/psychiatric problems ____

____

Drug allergies: Yes ______ No______ If yes, please list ____

Please list any and all medications with doses including over-the-counter drugs, herbs, and birth control pills.

____

Please list past hospitalization and/or surgeries including dates: ____

____

Review of Systems: Please check symptoms you currently have or have had in the past year:

____Depression	**____Dizziness/Vertigo**	**____Fever**
____BipolarDisorder	**____Difficulty swallowing**	**____Tremor**
____Nausea/Vomiting	**____Muscle spasm**	**____Parkinson's**
____Pain, weakness or numbness	**____Multiple sclerosis**	**____Impaired memory**
____Visual impairment	**____Lou Gehrig's Disease**	**____Alzheimer/dementia**
____Migraine/headache	**____Neuropathy/diabetic, etc.**	**____Myasthenia Gravis**
____Syncope	**____Diabetes**	**____Stroke/TIA**
____Seizure/type________	**____Difficulty walking**	**____Fainting/blackout**
____Falls/Incoordination	**____Low back pain, etc.**	

TOBACCO USE: (INCLUDING SMOKELESS TOBACCO): ____YES _____NO IF YES, FREQUENCY:__________________

ALCOHOL USE: ____YES ____NO IF YES, FREQUENCY____

PATIENT/LEGAL GUARDIAN SIGNATURE:____

PATIENT INFORMATION SHEET

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NASROLLAH ESLAMI, M.D., BOARD CERTIFIED NEUROLOGIST

Please carefully answer the questions below. This is confidential and will become a part of your medical record. Please print.

NAME:________________________________ DOB:__________________AGE:_______________ SEX:______________

ADDRESS:____

(STREET) (CITY) (STATE) (ZIP)

HOME PHONE: _____________________ CELL PHONE ______________________ALTERNATE NUMBER ______________

SS#: _______________________MARITAL STATUS:__________________

PRIMARY INSURANCE:_________________________GROUP#________________ CONTRACT#_____________________

SUBSCRIBER'S NAME:_________________________ SUBSCRIBER'S DOB_______________________________________

EMPLOYER ________________________________ ADDRESS:____

PRIMARY CARE PHYSICIAN: ______________________ REFERRING PHYSICIAN: _________________________________

EMERGENCY CONTACT NAME AND PHONE:___________________ (HOME)________________(CELL)________________

<u>STATEMENT OF FINANCIAL RESPONSIBILITY</u>: I understand that I am directly responsible to Neurology-Neurodiagnostic Lab, LLC for all charges of medical services rendered to myself or my family members, regardless of insurance coverage. I agree to pay my collections/attorney fees for delinquent accounts as well as any fee for appointments not kept or cancelled without 24 hour notice.

<u>AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:</u> I hereby authorize release of information required for insurance claim purposes. In addition, the signature below is my authorization of assignment of insurance benefits to the Neurology-Neurodiagnotic Lab.

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATION

By signing below you hereby consent for The Neurology-Neurodiagnostic Lab (Practice) to disclose information about you for the sole purpose of treatment, payment and health care operations. You may refuse to sign this consent form. You also have the right to request that the practice restrict how your personal health information is used to disclosed in carrying out treatment, payment or health care operations. Please be aware, however that the practice is not required to agree to these requested restrictions. Should the practice agree to your request restrictions though, the restrictions are binding. Information about your is protected under federal law and you have the right to revoke this consent at any time. This revocation will not apply to action(s) the practice has already taken in reliance on your consent (as determined by our privacy officer). By signing below, you recognize that the protected health information used or disclosed may be subject to redisclosure by the recipient and my no longer be protected under federal law.

The practice may communicate confidential information, including payment invoices, to me at the following address and/or phone numbers (including leaving messages):

ADDRESS:_____________________________________ PHONE: ____

_____________________________________ ____

I authorize the following persons to communicate on my behalf with the practice concerning my medical care:

NAME: ______________________________________ RELATION: ____

NAME: ______________________________________ RELATION: ____

PATIENT/LEGAL GUARDIAN SIGNATURE: ____ DATE: _________________________