

PATIENT HISTORY

PATIENT NAME _____ DATE _____

How did you hear about us? Doctor Family Friend Yellow Pages Ad Other

Referring doctor's name: _____ Telephone No. _____

Family doctor's name: _____ Telephone No. _____

Reason for today's visit: _____

PERSONAL HISTORY

Do you have, or have you had the following problems:

Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swallowing Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Angina (heart pain)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nasal Polyps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lyme Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/>
No					
Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other _____

Please list any medications to which you are allergic? _____

Please list any medications you are currently taking: _____

Please list any surgeries and/or hospitalizations: _____

Do you drink alcohol? Yes No If yes, how much? _____

Do you smoke? Yes No If yes, what do you smoke and how much? _____

Are you pregnant? Yes No

Do you take caffeine? Yes No If yes, how much? _____

Do any of your immediate family members (blood relatives) suffer from:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Narcolepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete this page!

As a workers compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. The patient is ultimately responsible for any unpaid balance.

Are you seeing the doctor for a work related injury? Yes No If yes, date of injury: _____

Worker's Compensation Claim Number: _____ Insurance Carrier: _____

Phone Number: _____ Contact Person: _____

Insurance Address: _____

Name of Employer: _____ Employers Phone Number: _____

We will obtain a copy of your insurance cards, but ask that you complete these sections, if applicable. The "Insured" refers to the individual who subscribes to the insurance plan, for instance, through their employer.

Primary Insurance: _____
I.D. Number: _____
Group Number/Plan: _____
Name of Insured: _____
Social Security Number of Insured: _____
Insureds Date of Birth: _____

Secondary Insurance: _____
I.D. Number: _____
Group Number/Plan: _____
Name of Insured: _____
Social Security Number of Insured: _____
Insureds Date of Birth: _____

PLEASE NOTE: If your insurance is an HMO, you must have a referral for every visit. Your Primary Care Physician writes this referral and you must present it each time you are seen in our office. Occasionally, your Primary Care Physician will allow for more than one (1) visit. If this is the case, the first visit must occur within thirty (30) days of the date of the referral or it will be considered invalid. Additionally, depending on your insurance plan, your referral may expire before all of the authorized visits are used. In this case, you will be required to obtain a new referral prior to your office visit. Please note that it is the patient's responsibility to obtain a referral and verify that it is accurate and current. Our office will not obtain referrals and you will be asked to reschedule your appointment should you arrive without one. If you have a question regarding your insurance or how to obtain a referral, please contact your Primary Care Physician.

Patient's Initials: _____

Acknowledgement

I have reviewed or received a copy of the Privacy Policy and Office Policy.

Notice of Privacy Policy _____

Office Policy _____

REGISTRATION

PATIENT INFORMATION (Please print and complete all information)

Last Name: _____ Sex: F M Age _____ Date of Birth: _____

First Name: _____ Middle Initial: _____ Home Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ SSN: _____

Person to contact if Patient is a minor: _____ Daytime Phone: _____

Cell Phone: _____ E-Mail Address _____ Yes No For appt reminders by e-mail

Patient's Marital Status Single Married Separated Divorced Widowed

Patient's Employer _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employment Status: Full Time Part Time Unemployed Retired

Have you or any family members been seen here before? Yes No If yes, who? _____

Have you been seen by Doctors Kerasidis or Forrest, in the hospital prior to today's visit? Yes No

INSURED (Name of the person the insurance is through, disregard if same as patient)

Relationship of Patient to Insured: Husband Wife Parent Child Adopted Child Other

Last Name: _____ Sex: F M Age _____ Date of Birth: _____

First Name: _____ Middle Initial: _____ Home Phone: _____

Street Address: _____ Work Phone: _____

City: _____ State: _____ Zip Code: _____ SSN: _____

Marital Status Single Married Separated Divorced Widowed

Employer: _____

Employer Address: _____

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable and that a copy of this authorization can be used in place of the original. I allow fax transmittal of my medical records, if necessary. I understand that my insurance is a contract between myself and my insurance company and Chesapeake Neurology Associates assumes no responsibility for unpaid claims. I authorize claims to be billed electronically. I understand and agree that I am responsible for any charges not paid by insurance after ninety (90) days. I acknowledge full financial responsibility for services rendered by Doctors Kerasidis, Forrest, Schmalz, Karen Williams, CRNP, and Susan Kissel, CRNP, including deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" including appeals and rejections by my insurance company. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. Interest will accrue at 18% annually on all unpaid balances. **I understand that there is a \$25.00 return check fee. I also understand that 24 hours notice is required for cancellations. A \$50.00 "No Show" fee will be charged for new patients and \$25.00 for all other patients, if 24 hours notice is not given for a broken appointment.** I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and assign insurance payments to be made directly to Harry Kerasidis, M.D. should they

elect to receive such payment. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date _____ Signature _____