PATIENT REGISTRATION INFORMATION

Dr. Moustafa Aly

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN(If Different): _____

PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex**: ☐ Male ☐ Female

Name: _____

Address: _____ City, State, Zip: _____

Social Security # _____-_____-_____ Date of Birth :_____/_____/_____

Cell Phone: (____) _____ Home Phone: (____) _____

Email Address: _____

PATIENT'S INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

PHARMACY INFORMATION

Name: _____ City: _____

Name: _____ City: _____

EMERGENCY CONTACT

Name: _____ Phone: (____)_____

Relationship: _____

MARKETING

How did you hear about us? _____

EMPLOYER:

Name: _____ Number: _____

Assignment of Benefits/Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Noydeen Medical Group and any physician for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Signature: _____ Date: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

The signature below acknowledges a copy of the notice was RECEIVED (not necessarily read).

Patient Signature: _____ Date: _____

Patient Representative: _____ Relationship: _____

ADDENDUM: PATIENT PRIVACY

I, _____, authorize Noydeen Medical Group to share pertinent "Protected Health Information" with my immediate family members, significant others or care givers present today as noted below:

Please **PRINT** the name clearly:

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

I understand that I can withdraw the above at any time, with written request, I also understand that it is my responsibility to ensure that my family member, significant other or care giver, do not divulge or use the information in any way without discussing with me first.

Patient Printed Name: _____ Date: _____

Patient Signature: _____ Date of Birth: _____

Patient Representative: _____ Relationship: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize Noydeen Medical Group to RELEASE /SEND my health information TO the following:

Name: _____

Address: _____

Phone: _____ Fax: _____

I authorize Noydeen Medical Group to OBTAIN/RECEIVE my health information FROM the following:

Name: _____

Address: _____

Phone: _____ Fax: _____

Description/Dates of information that may be USED/DISCLOSED:

Entire Record? Yes or No

Specified Dates: _____

Information will be used/disclosed for the following purpose: _____

_____

- I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations. The information described above may be re-disclosed and no longer protected by these regulations.
- I understand that Noydeen Medical Group will be paid for the costs of copying the information to be released.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information USED/DISCLOSED under this authorization.
- I understand that I may revoke this authorization in writing at any time by delivering a copy of the revocation to Noydeen Medical Group.

This authorization expires ninety (90) days from the date below:

Patient Name: _____ Date: _____

Date of Birth: _____ Phone: _____

Patient Representative: _____ Relationship: _____

CANCELLATION/NO-SHOW POLICY

CANCELLATIONS:

We value all our patients and strive to provide the best patient care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your medical needs, reserving a room and preparing your records. We kindly ask that if you must change an appointment, please give us a 24-hour notice. This courtesy makes it possible to give your reserved time to another patient who is needing to be seen. If you cannot give us a 24-hour notice, please call us as soon as possible to let us know that you cannot make it to the appointment. We know that your time is valuable and appreciate your cooperation with our policy.

NO-SHOW APPOINTMENTS:

A "NO-SHOW" is defined as missing an appointment without calling us to cancel. We understand that the occasional missed appointments can occur for a variety of reasons. When you do not come to your appointment, not only are you not being seen, but you are preventing another patient from being seen.

Our policy is as follows:

1st No-Show: We will send a letter and reach out to you by phone to get your appointment rescheduled.

2nd No-Show: We will send a letter, reach out to by phone and you will incur a $25 fee added to your chart. No discounts or refunds will be issued for these charges. Your payment will be due in addition to any copay's that you may have at your next visit.

3rd No-Show: After the 3rd no-show, we will send you a letter of dismissal from the practice. We will offer 30 days of emergent care only and will send your medical records to your new physician.

I have read and understand the above policies. Any questions that I have regarding this policy has been answered and copy provided to me.

_____ _____

Patient Signature Date Signed

_____ _____

PRINTED name of patient Date of Birth

NEUROLOGY QUESTIONNAIRE

Name : _____

REASON FOR THE VISIT

- What issue do you need to see Neurology for ? _____
- How long have you had this issue ? _____
- What are your goals for this evaluation ? _____
- Have you seen any other physician for this problem ? Yes or No
  - If yes, what was your diagnosis ? _____
- What have you tried that ? What worked for you and what didn't ?

  _____

  _____
- Do you experience any other symptoms ? Yes or No
  - If yes, what were they ? _____

    _____
- Does anyone in your family have similar problems ? Yes or No
  - If yes, what are their problems ?_____

    _____

Please check the following tests that you have had performed and if you brought the records/imaging with you to for Dr Mehaffey to review.

☐ CT of the Brain	Reports/Imaging ? Yes or No
☐ CT of the Spine	Reports/Imaging ? Yes or No
☐ CTA of the blood vessels in Head/Neck	Reports/Imaging ? Yes or No
☐ Carotid Ultrasound	Reports/Imaging ? Yes or No
☐ MRI of the Brain	Reports/Imaging ? Yes or No
☐ MRI of the Spine	Reports/Imaging ? Yes or No
☐ MRA of blood vessels in Head/Neck	Reports/Imaging ? Yes or No
☐ Sleep Study	Reports/Imaging ? Yes or No
☐ Lumbar Puncture (Spinal Tap)	Reports/Imaging ? Yes or No
☐ EMG/Nerve Conduction Study	Reports/Imaging ? Yes or No

HEALTH HISTORY

Name : _____ Date of Birth : _____

Height : _____ Weight : _____

****Please consider your <u>current</u> health status, as well as your medical history,**

EVEN if issues are resolved.**

Have you EVER had any of the following medical conditions ? (Mark all that apply.)

- ☐ Depression
- ☐ Anxiety
- ☐ Abuse/Trauma
- ☐ Other Mental Health Diagnosis : _____
- ☐ Arrhythmia/Atrial Fibriillation
- ☐ Heart Attack/Heart Problems
- ☐ Autoimmune Disease
- ☐ Birth Injury/Developmental issues/Blood Clots/Cancer/Brain Tumor/Surgery
- ☐ Head or Neck Injury/Concussion/Headaches or Migraines/High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/other infection
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loss of consciousness

Any other Medical Conditions ? _____

Have you had any previous Surgeries? (Include Approximate dates)

Date	Surgery	Reason

Have you ever been hospitalized for any of the following ? (Circle all that apply)

Pregnancies	Sleep Apnea	Lung Problems	Seizures/Epilepsy
Multiple Sclerosis	Meningitis/Encephalitis	Osteoporosis	Stroke
Thyroid Disease	Diabetes		

Medications: Please list all current medications (including over-the-counter medications and vitamins), dosages, how you take them and who prescribes them

Medication	**Dosage**	**Frequency**	**Prescribing Dr.**

Allergies: Please list all allergies.

_____

_____

_____

PERSONAL HISTORY

List any family members that have had the following. (M=Mother, F=Father, B=Brother, S=Sister)

- ☐ Alcohol or Substance/Drug Addiction M F B S
- ☐ Anxiety M F B S
- ☐ Depression M F B S
- ☐ Suicide M F B S
- ☐ Blood Clots M F B S
- ☐ Cancer(include Type) _____ M F B S

Who lives at home ? _____

Childrens's Names and Ages ? _____

Religion/Spiritualty (optional) ? _____

Highest Level of Education ? _____

Previous/Current Occupation ? _____ Satisfied ? Y N

How is your sleep quality ? _____ Hours of Sleep/night ? _____

What are your exercise habits ? _____ Do you diet ? Y N

How much caffeine do you consume daily ? _____ Energy Drinks ? Y N

What is your stress level ? Low Med High What are your stressors ?_____

How do you relieve stress ? _____ What do you do for fun ? _____

_____

HEALTH RISKS

Do you smoke? YES NO

- If yes, Packs/day _____ for _____ years. Start Date? _____

Previous Smoker? YES NO

- If yes, Packs/day _____ for _____ years Quit Date? _____

Do you use smokeless tobacco products? YES NO

- If yes, What? _____How much? _____

Do/Have you use any form of illegal substances? YES NO

- If yes, What? _____How often? _____

Do you drink alcohol? YES NO

- If yes, What? _____How often? _____

Do you have any firearms in your home? YES NO

- Are they Locked and unloaded? YES NO

Do you or anyone in your life have concerns about your driving safety? YES NO

- If yes, please explain(Accidents? Tickets? Getting lost?)_____

Do you need assistance doing household chores, getting dressed/showering, eating, toileting, etc? YES NO

- If yes, please explain: _____

Do you use medical equipment (cane, walker, etc)? YES NO

- If yes, please explain: _____

VACCINES (Are they up to date?)

- ☐ Influenza Vaccine: YES NO Date:_____
- ☐ Pneumonia Vaccine: YES NO Date:_____
- ☐ Shingles (Zostavax)Vaccine: YES NO Date:_____

Is there anything else you would like to share ? _____

_____

WOMEN ONLY

OB/Gynecologist name? _____

Clinic Name : _____ Phone : _____

Age of 1st menstrual period :_____ Date of last cycle ? _____

Are you planning to become pregnant ? YES NO If yes, When ? _____

How many pregnancies have you had ? _____

Are you currently breastfeeding ? YES NO

What form(s) of birth control do you use ? _____