Patient Demographic Form

Please PRINT

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname/AKA**

Date of Birth **Social Security Number** **Gender** ☐ Male ☐Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other **Language** other than English

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone** **Email**

PARENT/GUARDIAN INFORMATION (if patient is a minor)

Parent/Guardian #1: **Relationship to Patient** ☐ Mother ☐ Father ☐ Other _____

Last Name **First Name** **Middle Initial** **Date of Birth**

Home Address (if different than patient) **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone** **Email**

Parent/Guardian #2: **Relationship to Patient** ☐ Mother ☐ Father ☐ Other _____

Last Name **First Name** **Middle Initial** **Date of Birth**

Home Address (if different than patient) **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone** **Email**

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Who is the responsible party/guarantor? ☐ Self/Patient ☐ Guardian #1 from above ☐ Guardian #2 from above ☐ Other (complete below)

Last Name **First Name** **Middle Initial** **Date of Birth**

Home Address (if different than patient) **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone** **Email**

Relationship to Patient:

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician Name **Primary Care Physician Address** **Primary Care Physician Phone**

Referring Physician Name **Referring Physician Address** **Referring Physician Phone**

PREFERRED PHARMACY INFORMATION

Pharmacy Name **Pharmacy Address** **Pharmacy Phone #** **Pharmacy Fax #**

Atlanta Headache Specialists

Review of Systems

Patient's Name: _____ DOB: _____

Email (to receive receipts & statements): _____

Patient's Current Medications and Dosage: need refill?

_____ _____

_____ _____

_____ _____

Drug Allergies: _____

Have you had any recent hospitalizations? _____ when/where? _____

Have you had any recent labs or procedures? _____ when/where? _____

Review of Systems: Please indicate if you have had any medical problems in the following areas, with approximate dates.

	Yes	No	Comments
Recent fever or weight loss	☐	☐	_____
Eye problems (cataracts, blindness, etc.)	☐	☐	_____
Ear, nose or throat problems	☐	☐	_____
Heart/Blood Pressure/Blood Abnormalities	☐	☐	_____
Respiratory problems (asthma)	☐	☐	_____
Gastrointestinal/Stomach problems (vomiting, pain)	☐	☐	_____
Musculoskeletal problems (joint or bone)	☐	☐	_____
Skin problems (rashes, acne, etc.)	☐	☐	_____
Neurological problems (seizure, headache, stroke)	☐	☐	_____
Thyroid problems, Diabetes	☐	☐	_____
Allergies (Food, Seasonal)/Immunologic	☐	☐	_____
Psychiatric problems (depression, anxiety)	☐	☐	_____
Sleep (trouble falling or staying asleep, snoring)	☐	☐	_____
Other not listed above	☐	☐	_____

Patient Signature: _____ Date: _____

ATLANTA HEADACHE SPECIALISTS

Medical Information Form

Patient Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY

Please describe any past medical problems you may have had. Where possible, give dates of illnesses/surgeries:

Major illnesses requiring hospitalization:

1. _____
2. _____
3. _____

Surgeries

1. _____
2. _____

Other known medical problems not listed above

1. _____
2. _____

PAST FAMILY MEDICAL HISTORY

Please describe any medical problems that exist or have existed in close family members. List the problem and affected individual(s) if known.

1. _____
2. _____
3. _____

_____ _____

Signature of patient Date

Patient Policies

(Atlanta Headache Specialists)

We want to make sure you are aware of what to expect from our practice. The following is a list of our Patient Policies that address financial, appointments and clinical policies. We ask that you read the policies and sign below.

PAYMENT POLICIES

- If your managed care plan requires a referral to see a specialist, you are responsible for making sure your PCP (primary care provider) has completed this.
- All co-payments, co-insurance, deductibles, and non-covered service fees are due at the time of service, as per our contract with your insurance carrier.
- If your account is sent to our collection agency for non-payment, the patient will be discharged from our practice until the balance is paid in full.

APPOINTMENTS

- 24 hour notice (of your appointment time) is requested for cancellation of an appointment. For Monday appointments, please call on Friday. Cancellation notice within less than the requested time will result in a $100 cancellation fee for new patient appointments and $50 cancellation fee for existing patients.

PRESCRIPTION REFILLS

- Prescription refills will only be completed during regular office hours. Patients must be seen within the recommended time frame given by the medical provider or a minimum of 6 months, whichever is less.
- Refill requests will be completed within 2 business days of request.
- For patients on a Controlled Substance, the patient must be seen a minimum of every 3 months to receive refills.

MEDICAL RECORDS AND FORM COMPLETION REQUESTS

- All medical-records requests must be in writing and received in our office 7-10 days prior to the date needed.
- A fee will be charged for completion of all forms, either as an annual fee of $35 that covers the completion of all accepted forms for a year or a $20 per form fee.

Thank you for reading through these policies. We appreciate your understanding of having these policies in place.

I have read and agree to abide by the policies as described above.

Patient Name: _____ Date of Birth: _____

Signature of Patient/Legal Guardian: _____

Date: _____

Patient Financial/Communication Statement

Please read thru the following financial and communication statements and sign where indicated.

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Date of Birth**

FINANCIAL STATEMENTS

1. FINANCIAL RESPONSIBILITY:

I understand that I am personally responsible for any medical fees I will incur with Atlanta Headache Specialists/PANDA Neurology and that all co-payments, co-insurance, and deductibles are due at the time of service. I also understand that I will be responsible for all charges incurred by not providing the most current, correct insurance information to Atlanta Headache Specialists/PANDA Neurology.

Signature of Patient or Parent/Legal Guardian: _____

2. AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Atlanta Headache Specialists/PANDA Neurology to release medical information acquired in the course of me or my child's examination or treatment, to my insurance company, or other physicians required to participate in my care.

Signature of Patient or Parent/Legal Guardian: _____

3. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment for medical services provided directly to Atlanta Headache Specialists/PANDA Neurology.

Signature of Patient or Parent/Legal Guardian: _____

4. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY:

I acknowledge that I have received a copy of Atlanta Headache Specialists/PANDA Neurology's Privacy Policy.

Signature of Patient or Parent/Legal Guardian: _____

COMMUNICATION WITH PATIENT

1. If you are unavailable, may we leave medical information, such as normal blood test results:

- on your home phone voicemail ☐ yes ☐ no
- on your cell phone voicemail ☐ yes ☐ no
- with someone at your residence ☐ yes ☐ no

Signature of Patient or Parent/Legal Guardian: _____

2. May we confirm future appointments to our office:

- on your home phone voicemail ☐ yes ☐ no
- on your cell phone voicemail ☐ yes ☐ no
- text message to your cell phone ☐ yes ☐ no
- with someone at your residence ☐ yes ☐ no

Signature of Patient or Parent/Legal Guardian: _____

3. I give permission for PANDA & Atlanta Headache Specialists to discuss my medical care with (for non-minor patients):

Name _____ Relationship: _____ Phone #: _____

Name _____ Relationship: _____ Phone #: _____

Signature of Patient or Parent/Legal Guardian: _____

Patient Insurance Form

Please PRINT

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname/AKA**

Date of Birth **Social Security Number**

FIRST (PRIMARY) INSURANCE INFORMATION

Carrier Name **Claims Address** (from back of insurance card)

Subscriber's Name **Subscriber's Date of Birth** **Subscriber's Employer Name**

Subscriber's Address (if different than patient's)

Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other

Policy # **Group #** **Effective Date**

☐ **HMO** ☐ **PPO** ☐ **POS**

SECOND (SECONDARY) INSURANCE INFORMATION

Carrier Name **Claims Address** (from back of insurance card)

Subscriber's Name **Subscriber's Date of Birth** **Subscriber's Employer Name**

Subscriber's Address (if different than patient's)

Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other

Policy # **Group #** **Effective Date**

☐ **HMO** ☐ **PPO** ☐ **POS**

THIRD (TERTIARY) INSURANCE INFORMATION

Carrier Name **Claims Address** (from back of insurance card)

Subscriber's Name **Subscriber's Date of Birth** **Subscriber's Employer Name**

Subscriber's Address (if different than patient's)

Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other

Policy # **Group #** **Effective Date**

☐ **HMO** ☐ **PPO** ☐ **POS**

Note: Please make sure you provide us a copy of each insurance card. If your insurance changes, please let us know so we can update your records. Thanks.