BHARAT M. TOLIA, M.D.
PATIENT REGISTRATION FORM

DATE: _____ REFERRED BY: _____

PATIENT NAME: _____

RESPONSIBLE PARTY (IF A MINOR): _____

STREET ADDRESS: _____ PHONE NUMBER: _____

CITY _____ STATE: _____ ZIP: _____

SEX: M F AGE: _____ Birthdate: _____

PATIENT EMPLOYED BY: _____

OCCUPATION: _____

BUSINESS PHONE: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE): _____

PHONE: _____

SOCIAL SECURITY NUMBER: _____

SPOUSE'S SOCIAL SECRITY NUMBER: _____

DO YOU HAVE MEDICAL INSURANCE: YES NO WORK COMP. _____ Auto _____

NAME OF PRIMARY INSURER: _____

CONTRACT NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER NUMBER: _____ CLAIM ID NUMBER: _____

SECONDARY INSURANCE: _____

ADDRESS: _____

HOW DID YOU LEARN ABOUT OUR PRACTICE? _____

ASSIGNMENT RELEASE:

I THE UNDERSIGNED, HAVE INSURANCE WITH: _____
NAME OF INSURANCE

AND ASSIGN DIRECTLY TO DR. BHARAT TOLIA ALL MEDICAL BENEFITS (IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.) I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL OF MY INSURANCE SUBMISSIONS.

_____ _____
DATE SIGNATURE OF INSURED/GUARDIAN

REVIEW OF SYSTEMS QUESTIONAIRE COMPLETED BY: (STAFF) (PATIENT) (PHYSICIAN) ON __/__/__
NAME: (MALE) (FEMALE)

Adult History and Review of Systems Questionnaire

Notes: This is a confidential record of your medical history. As your doctors, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Name _____ Date _____

Date of Birth _____ ☐ Male ☐ Female Spouse\Significant Other _____

SOCIAL HISTORY:

Birthplace _____ Your Occupation _____

Nationality _____ Education _____

Religion _____ Marital Status _____ How many years _____

Drug Use _____ Children _____

Tobacco Use ☐ Yes ☐ No Type _____

Packs per day _____ for _____ years Quit _____

Alcohol Use _____ Pets _____

Drinks _____ per ☐ day ☐ week ☐ month Exercise (type/how often?) _____

Recent or Frequent Travel Destinations _____

If heavy use, how many years _____ Quit _____

Caffeine (coffee, tea, soda, chocolate) Servings per day _____

Have YOU ever had? (IF YES, CHECK APPROPRIATE BOXES)

- ☐ Cancer Type: _____
- ☐ Heart Attack/Coronary
- ☐ Artery Disease
- ☐ Rheumatic Fever
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Gallstones
- ☐ Liver Disease
- ☐ Hepatitis/Jaundice
- ☐ Ulcer disease
- ☐ Heartburn / Reflux
- ☐ Asthma
- ☐ Seizures
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Positive TB Skin Test
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout
- ☐ Frequent Bladder Infection
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Polio
- ☐ Chicken Pox
- ☐ Infectious Mono
- ☐ Anemia
- ☐ Frequent Sinus Infections
- ☐ Glaucoma
- ☐ Thyroid Trouble
- ☐ Hives
- ☐ Depression
- ☐ Head Injury
- ☐ Broken Bones
- ☐ Blood transfusions
- ☐ Sexually Transmitted Diseases: Herpes, HIV, ☐ Gonorrhea, Chlamydia, ☐ Syphilis
- ☐ Intravenous drug abuse
- ☐ Needle injury
- ☐ Mumps
- ☐ Migraines
- ☐ Prostate Enlargement
- ☐ Cystic Fibrosis
- ☐ Malaria
- ☐ Other _____

IMMUNIZATIONS:
- ☐ Measles, Mumps and Rubella Vaccine
- ☐ Chicken pox vaccine
- ☐ Hepatitis B vaccine
- ☐ Influenza vaccine
- ☐ Pneumococcal vaccine
- ☐ Tetanus booster

PAST SURGICAL HISTORY: If yes, please check the box and enter the year.

- ☐ Eyes (Laser or Vision Corrected) _____
- ☐ Eyes (Cataract/Glaucoma) _____
- ☐ Ears _____
- ☐ Sinus/Nasal Septum _____
- ☐ Tonsils/Adenoid _____
- ☐ Thyroid _____
- ☐ Heart _____
- ☐ Stomach _____
- ☐ Varicose Veins _____
- ☐ Gall Bladder _____
- ☐ Appendix _____
- ☐ Intestine/Colon _____
- ☐ Hemorrhoids _____
- ☐ Hernia _____
- ☐ Breast _____
- ☐ Uterus/Hysterectomy _____
- ☐ Ovaries _____
- ☐ Spinal Surgery/Neck _____
- ☐ Prostate _____
- ☐ Spinal Surgery/Back _____
- ☐ Orthopedic (Hips/ Knee _____
- ☐ Shoulder/ Feet/Hands) _____
- ☐ C-section _____
- ☐ Vasectomy _____
- ☐ Tubal Ligation _____

☐ OTHER _____

ALLERGIES and Bad Reactions to Medications: _____ _____

_____ _____

_____ _____

MEDICATIONS: Name Dosage Times a day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Has anyone in your FAMILY ever had? (If yes check box and list relationship)

- ☐ Cancer & Type _____
- ☐ Diabetes _____
- ☐ Cardiac Dysrhymthia _____
- ☐ Congestive Heart Failure _____
- ☐ Coronary Artery Disease _____
- ☐ Valvular heart Disease _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Stroke _____
- ☐ Kidney stones _____
- ☐ Kidney disease _____
- ☐ OTHER _____

- ☐ Dialysis _____
- ☐ Chronic lung disease _____
- ☐ Tuberculosis _____
- ☐ Rheumatoid Arthritis _____
- ☐ Thyroid trouble _____
- ☐ Osteoporosis _____
- ☐ Cystic Fibrosis _____
- ☐ Asthma _____
- ☐ Peptic Ulcer _____
- ☐ Gallstones _____

- ☐ Crohn's/colitis _____
- ☐ Alzheimer's _____
- ☐ Alcoholism _____
- ☐ Bleeding tendency _____
- ☐ Anemia _____
- ☐ Gout _____
- ☐ Depression _____
- ☐ Mental illness _____
- ☐ Seizures _____
- ☐ Migraine headaches _____

GYNECOLOGICAL/ OBSTETRICAL HISTORY:

Name of OB-GYN _____

Age when you Started Menstruating? _____

Date of Last PAP? _____

History of abnormal Pap's Yes / No (Please circle)

Date of Last Mammogram? _____

History of Abnormal Mammograms Yes / No (Please circle)

Menstrual Cycles? Regular / Irregular (Please Circle)

Pain with Periods? Yes / No (Please Circle)

Number of Pregnancies? _____

Number of Births? _____

Vaginal / C-section (Please Circle)

Method of Contraception _____

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain >10 pounds
- ☐ Weight Loss >10 pounds

SKIN
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

HEENT
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Ear Ringing
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat

NECK
- ☐ Neck Pain
- ☐ Swollen Glands

RESPIRATORY
- ☐ Chronic Cough
- ☐ Decreased Exercise Tolerance
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Sputum Production
- ☐ Wheezing

BREAST
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Pains with walking
- ☐ Leg Swelling
- ☐ Night Awakening due to trouble Breathing
- ☐ Palpitations
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

GENITOURINARY
- ☐ Vaginal Discharge
- ☐ Menstrual Irregularities
- ☐ Difficulty Starting/Stopping urinary Stream
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Retention
- ☐ Urethral Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Mass
- ☐ Testicular Pain

MUSCULOSKELETAL
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Aches/Pains

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in Sleep Pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal Thoughts

ENDOCRINE
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

COMPREHENSIVE NEUROLOGY HEADACHE AND SLEEP CENTER

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of Comprehensive Neurology Headache and Sleep Centers, the office of Dr. Bharat Tolia, Notice of Privacy Practices.

_____ _____

Signature of Patient of Legal Guardian Date

_____

Patients Date of Birth

HIPPA Compliant Authorization to use or Disclose Protected Health Information (PHI)

NAME:_____DOB:_____/_____/_____SSN#_____
Address:_____ Phone# (____)_____
City:_____State:_____ZIP:_____

I hereby authorize_____(name of facility) Phone#_____
to disclose medical record information and/or protected health information (PHI)of the above listed patient to: Patient information

Requestor's Name:_____Phone# (___)_____
Requestor's Address:_____Fax# (___)_____
City:_____ State:_____ Zip:_____

Disclose the following protected health information for treatment dates_____to_____

The above information is disclosed for the following purposes:

Medical____ Legal____ Insurance____ Personal _____ Other_____

Office notes____ Test results_____ Insurance_____

Radiology_____ Entire chart_____ Labs/Pathology_____

I _____acknowledge and hereby consent to such, that the release of information may
(Initials) contain alcohol/drug abuse, psychiatry, HIV, AIDS information or genetic information.

This authorization shall expire 6 months after signed unless otherwise notated. EXP date:_____

- I understand I have the right to revoke this authorization at any time. I understand that if I do revoke this authorization I must do so in writing and that the revocation will not apply to any information that has already been released to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.
- Fee/Charges will comply with all laws and regulations applicable to release of information
- I understand authorizing the use or disclosure of the information identified above is voluntary, I need not sign this form to ensure healthcare treatment by this facility or any other facility.
- A photocopy of this authorization shall be considered as effective and valid as the original.
- I understand I may refuse to sign this authorization.

Signature:_____ Date:_____
Signature of witness:_____ Date:_____

ATTENTION

There will be a $50.00 charge for the following:

- Walking out of a scheduled appointment
- Not showing up for a scheduled appointment
- Cancelling without a 24 hour notice
- Being unable to keep your appointment due to lack of referral

All sleep studies and 72 hour EEG's MUST be cancelled 48 hours in advance.

There is a $150.00 cancellation/no show charge for sleep studies and 72 hour EEG's.

There is a $50.00 cancellation/no show charge for testing appointments (includes all ultrasounds, EMG's and 1 hour EEG's, and NeuroTrax)

There is a $50.00 charge for all forms and letters

The charge of medical records will be decided on per State of Florida or Michigan Guideline.

Fee/Balances MUST be paid in full before being completed

NO PRESCRIPTIONS WILL BE GIVIEN WITHOUT AN APPOINTMENT.

SIGNATURE

DATE

Letter of Understanding

I_____understand that I am required to keep all scheduled appointments.

NO prescriptions will be refilled if appointments are not kept.

I will be responsible for all health consequences from not keeping my appointment.

Thank You,

Dr. Tolla

_____ _____

Signature Date