KLINGS NEUROLOGICAL CARE PLLC

Our Commitment, Your Outstanding Care .... Always.

445 Dolley Madison Road. Suite 210. Greensboro. NC. 27410. Tel: 336.813.6043. Fax: 336.283.9870.

Date: ___________

Name: ____
First Name | Middle Initial | Last Name

Address: ____
Street Address | City and State | Zip | County

Phone: (_____) ____________ Work: (_____) ____________ Cell: (____) ____________

Email Address: ____

Date of Birth: __________ Sex: Female Male Age: ______ Social Security #: ____________

Primary Language____________ Race/Ethnicity ____________

Marital Status:

Single
Married
Separated
Divorced
Widowed

Responsible Party's Name (minor): ____________________Social Security #: ____________

Address: ______________________________ Phone #: (____) ____________

Relationship to Patient: ______________________ Work #: (____) ____________

Spouse's Name: ____________________ Spouse's Employer: ____________________

Relative whom we can contact in the event of an emergency

Name: ____________________ Relationship: __________ Phone #: (_____) ____________

Address: ____
Street Address | City and State | Zip | County

Referring Doctor: ____________________ Primary Doctor: ____________________

Insurance Information

Primary Insurance & ID #: ____
Name of Insurance | Identification #

Name of Insured: ______________________________ Insured's DOB: ____________

Secondary Insurance: ____
Name of Insurance | Identification #

Name of Insured: ______________________________ Insured's DOB: ____________

Pharmacy Name: ______________________ Phone: ____________ Fax: ____________

Signature: ______________________________ Date: ____________

Describe why you are here to see us: ____

1. Location: Age and chief complaint: ____

   Where is your pain located? ____

2. Duration: How long have you had these symptoms? ______________________________

   Under what circumstances did your pain begin?

   ☐ No apparent reason ☐ Following Surgery ☐ Car Accident ☐ Work Related injury

   ☐ Other (specify) ____

3. Timing: How often do you experience pain?

   ☐ Constantly ☐ Nearly Constantly ☐ Greater than 50% of the time ☐ less that 50% of the time

   ☐ Infrequent (less than 20% of the time)

4. Context: Please check all that apply:

Do you have	☐ Pain	☐ Numbing	☐ Tingling
In your	☐ Arms	☐ Legs	☐ Both
Which side	☐ Left	☐ Right	☐ Both

5. Modifiers:

   What time of day is your pain the worse?

   ☐ Morning ☐ Afternoon ☐ Evening ☐ Nighttime

   What makes your pain worse? (Check those that apply)

☐ Lying flat	☐ Sitting	☐ Standing	☐ Bending forward	☐ Leaning back
☐ Twisting	☐ Walking	☐ Stress	☐ Driving	☐ Weather changes

   ☐ Other (please describe) ____

   What makes your pain better? (Check those that apply)

☐ Lying flat	☐ Sitting	☐ Standing	☐ Bending forward	☐ Leaning back
☐ Twisting	☐ Walking	☐ Stress	☐ Driving	☐ Weather changes

   ☐ Other (please describe) ____

MEDICATIONS

Please list all medications you are currently taking, including non-prescription medications

Patient Name ______________________________

Address ______________________________

____

Phone # ______________________________

Pharmacy
Name & Phone # ______________________________

Name of Medication	Strength	Frequency	Date Discontinued	Signature & Date

No

DRUG ALLERGIES: **(Please circle and list, if any)**

____

____

Health History

Name: ______________________ Date: ______________

Primary Doctor: ______________________

Past Medical History: Please check all that apply to you

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer, Type: __________
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Head Trauma/Concussion
- ☐ Headaches/Migraines
- ☐ Heart problems : Type__________
- ☐ Heart Surgery
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Psychiatric disease
- ☐ Stroke
- ☐ Thyroid
- ☐ Ulcer/GERD
- ☐ Blackouts
- ☐ High Cholesterol
- ☐ Other:

Allergies to medications: ______________________

Previous Surgeries and/or Hospitalizations: Please list past surgeries with approximate date:

____

____

____

____

Serious Injury: ______________________

____

____

Social History:

Occupation: ______________________

Marital Status: ______________ Children: __________

Do you drink alcohol? ☐ Yes ☐ No If yes, how much/week? __________

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes/day? __________

☐ Former Smoker ☐ Never Smoker

Do you consume caffeine? ☐ Yes ☐ No If yes, how many cups/day? ________ ☐ coffee ☐ tea ☐ soda

Do you use recreational drugs? ☐ Yes ☐ No If yes, what type and frequency? __________

Are you on a special diet? ☐ Yes ☐ No If yes, please describe? __________

Do you exercise regularly? ☐ Yes ☐ No

Family History: Do you know of any blood relative who has or had:

Condition	Relation	Condition	Relation
☐ Arthritis		☐ Kidney disease	
☐ Asthma		☐ Lung disease	
☐ Aneurysm, Type:		☐ Migraine	
☐ Brain tumor		☐ Multiple Sclerosis	
☐ Cancer, Type:		☐ Parkinson's	
☐ Dementia/Alzheimer's		☐ Peripheral Neuropathy	
☐ Diabetes		☐ Psychiatric disease	
☐ Epilepsy/Seizures		☐ Stroke	
☐ Headaches		☐ Thyroid	
☐ Heart Problems		☐ Other:	
☐ High Blood Pressure			

Comments: ______________________

____

____

Review of Systems

Please note any issues that have affected you <u>in the past year</u>:

Constitutional: ☐ Fever ☐ Chills ☐ Sweats ☐ Weakness ☐ Fatigue ☐ decreased activity ☐ No issues
Other ______

Eyes: ☐ Recent visual problem ☐ Jaundice (Icterus) ☐ Discharge ☐ Blurring ☐ Double Vision ☐ Visual disturbances ☐ No issues
Other ______

Ear, Nose, Mouth, Throat: ☐ Decreased hearing ☐ ear pain ☐ nasal congestion ☐ sore throat ☐ No issues
Other ______

Respiratory: ☐ shortness of breath ☐ sputum production ☐ coughing up blood (hemoptysis) ☐ wheezing ☐ Bluish skin tone (cyanosis) ☐ pause in breathing (apnea) ☐ No issues
Other ______

Cardiovascular: ☐ chest pain ☐ palpitations ☐ bradycardia ☐ tachycardia ☐ peripheral edema ☐ syncope ☐ No issues
Other ______

Gastrointestinal: ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ heartburn ☐ abdominal pain ☐ vomiting of blood (hematemesis) ☐ No issues
Other ______

Genitourinary/ Urinary: ☐ pain urinating (Dysuria) ☐ blood in urine (Hematuria) ☐ Change in urine stream ☐ urethral discharge ☐ lesions ☐ No issues
Other ______

Hema/Lymph: ☐ bruising tendency ☐ bleeding tendency ☐ swollen lymph gland ☐ No issues
Other ______

Endocrine: ☐ excessive thirst ☐ excessive urination (polyuria) ☐ cold intolerance ☐ heat intolerance ☐ excessive hunger ☐ No issues
Other ______

Immunologic: ☐ immunocompromised ☐ recurrent fevers ☐ recurrent infections ☐ lethargy (malaise) ☐ No issues
Other ______

Musculoskeletal: ☐ back pain ☐ neck pain ☐ joint pain ☐ muscle pain ☐ muscle weakness (claudication) ☐ Decreased range of motion ☐ trauma ☐ No issues
Other ______

Integumentary: ☐ rash ☐ itching (pruritus) ☐ abrasions ☐ breakdown ☐ burns ☐ dryness ☐ red spot on skin (petechial) ☐ Skin lesion ☐ hypertrophic scar ☐ keloid ☐ No issues
Other ______

Neurologic: ☐ abnormal balance ☐ confusion ☐ numbness ☐ tingling ☐ headache ☐ No issues
Other ______

Psychiatric: ☐ anxiety ☐ depression ☐ mania ☐ suicidal ☐ delusional ☐ hallucinations ☐ No issues
Other ______

Employment History

☐ **Full time** ☐ **Part time** ☐ **Medical leave of absence** ☐ **Retired** ☐ **Disabled** ☐ **Student**

☐ **Unemployed/Seeking work** ☐ **Unemployed/Not seeking work**

Your Occupation ____

Are you currently receiving disability? ☐ **Yes** ☐ **No**

If yes, why: ____

Do you currently receive or are you filing for worker's compensation? ☐ **Yes** ☐ **No**

If yes, please explain: ____

Are you currently involved in a law suit or legal action? ☐ **Yes** ☐ **No**

If yes, please explain: ____

445 Dolley Madison Road, Ste 201, Greensboro, NC 27410
Phone: 336-365-1001 Fax: 336-897-1533

Olukayode O. Onasanya, M.D.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, ______________________, ____________ authorize Kiings Neurological Care, PLLC to:
(Patient Name) (DOB)

Release From:

Practice/Physician ____________________

Address ____________________

____

Phone: ____________________
Fax: ____________________

Disclose To:

Practice/Physician ____________________

Address ____________________

____

Phone: ____________________
Fax: ____________________

For the following purpose:

___History and Physical Exam
___Diagnostic Test Results
___Medication Records
___Neurological Assessments and related studies
___Psychiatric/Psychological Assessments/studies
___HIV Status

___Admission Information
___Discharge Summary
___Treatment Plan(s)
___Progressive Reports
___Substance Abuse Information
___ Other: ____________

I understand this authorization will expire on the following date, event or condition: ____________________

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment services, or my eligibility for benefits. I understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that I am protected under NC G.S. 134A-143 and federal laws CFR 42 Part 2. I understand my rights concerning the release of HIV/AIDS and substance abuse history in my records and I have checked above if the information is wished to be released. I also understand that my information may not be protected from re-disclosure by the requester of the information. The recipient may not re-disclose such information without my further written authorization unless otherwise provided for by the state or federal law.

I further understand that I may request a copy of this signed authorization.

______________________________ ____________________ ____________
(Signature of Client/Personal Representative) (Relationship to Patient) (Date)

____
(Witnessed By)

Financial Responsibility Agreement

We are committed to meeting your healthcare needs in a reasonable manner. Our goal is to keep your insurance or other financial arrangements as simple as possible. **As a courtesy, Kiings Neurological Care, PLLC will file your claim with your Health insurance plan. Your plan may offer coverage, but generally there are eligibility requirements.**

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance company for my visits. This includes any medical services visit, EMG, EEG ordered by my physician or physician 's staff.

I understand and agree it is my sole responsibility and not the responsibility of the provider of services or technicians to know if my insurance will pay for my medical service, testing or visit ordered by my physician or the physician's staff.

I understand and agree it is my sole responsibility to know if my insurance has any deductibles, referral requirements, co-payment, co-insurance, out-of-network amount and usual and customary limit or any other type of benefit limitation for the services I receive, and I agree to make full payment promptly.

I understand that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied, or a higher out-of-pocket expense to me. I understand this and agree to be financially responsible and make full payment promptly.

I understand since scheduling of an appointment involves the reservation of time, specifically for you, a minimum of 24-hour notice is required for re-scheduling or canceling appointment without being charged the full rate for the appointment, which is not covered by insurance. Unless we reach a different agreement, a fee of $25 will be charged for sessions missed without such notification; this charge will be billed to your account and expected to be paid upon your next office visit.

I understand their will be a $35 returned check fee.

By signing below, I agree to accept full financial responsibility as a patient who is receiving any medical services, that may include EMG, EEG or as the responsible party or minor patients. My signature verifies that I have read the above disclosure statement, understand my responsibilities and agree to these terms.

Patient
Signature ______________________________ Date ____________________

Responsible Party Name (please print) ______________________________________

Responsible Party Signature ______________________________ Date ____________________