Rush Neurology, LLC
Bijay N. Pandey, M.D.
Patient Registration Form

Last Name: _____ **First Name:** _____ **MI:** _____

Sex:_____ **Race:**_____ **Language:**_____ **Marital Status:** _____**Email:**_____

Date of Birth: _____ **Social Security #:** _____

Home Address:_____
Street *City* *State* *Zip*

Home Phone: _____ **Work/Cell Phone:** _____

Primary Care Dr.: _____ **Referring Dr:** _____

Patient's Employer: _____ **Phone:** _____
Employer Address: _____
Street *City* *State* *Zip*

Spouse Name: _____ **Phone:** _____
Employer Address: _____
Street *City* *State* *Zip*

Emergency Contact (Name & Phone): _____

Primary Insurance Company: _____ **ID#** _____
Name of Policy Holder: _____ **Relationship:** _____ **Sex:** _____
Date of Birth: _____ **Social Security #:** _____

Secondary Insurance Company: _____ **ID#** _____
Name of Policy Holder: _____ **Relationship:** _____ **Sex:** _____
Date of Birth: _____ **Social Security #:** _____

SHARING INFORMATION WITH FAMILY & FRIENDS

To protect the confidentiality of our patients, we ask you to indicate whom you will allow us to discuss your medical care with. If you do not let us know with whom we may talk to, we will not discuss your medical care.

NAME	RELATION

PLEASE READ CAREFULLY

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rush Neurology, LLC or insurance company to release any information required to process my claims. I, the undersigned hereby acknowledge that I am responsible for payment of the services provided to me regardless of medical coverage. Rush Neurology, LLC will file any medical insurance on my behalf but it is my responsibility to insure my balance is paid within a reasonable time. **I the undersigned hereby acknowledge that I will be responsible for any office visits or procedures performed on me that are denied as not MEDICALLY NECESSARY.**

In addition, I am aware that if I cannot attend a scheduled appointment I must call at least 24 hours in advance to avoid a $50 no show fee.

SIGNATURE OF PATIENT: _____ **Date:** _____
SIGNATURE OF GUARDIAN: _____ **Date:** _____

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Health History Form

CONDITIONS ***Check conditions you currently have or have had in the past***

- ☐ **Alcoholism**
- ☐ **Alzheimer's Disease**
- ☐ **Anxiety Disorder**
- ☐ **Back Pain**
- ☐ **Bipolar**
- ☐ **Convulsions**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Difficulty Swallowing**
- ☐ **Dizziness**
- ☐ **Double Vision**
- ☐ **Fibromyalgia**
- ☐ **Headaches**
- ☐ **Heart Attack**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **HIV Positive**
- ☐ **Insomnia**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Loss of Appetite**
- ☐ **Lupus**
- ☐ **Memory Loss**
- ☐ **Multiple Sclerosis**
- ☐ **Neck Pain**
- ☐ **Pacemaker**
- ☐ **Pain in Arms/Legs (Circle)**
- ☐ **Parkinson's Disease**
- ☐ **Restless Legs**
- ☐ **Seizure Disorder**
- ☐ **Schizophrenia**
- ☐ **Sleep Apnea**
- ☐ **Stroke**
- ☐ **Suicide Attempt**
- ☐ **Tingling/Numbness Arms/Hands/Legs (Circle)**
- ☐ **Tremors**
- ☐ **Thyroid Problems**
- ☐ **Vision Loss**
- ☐ **Other**_____
  _____
  _____
  _____
  _____

Reason For Your Visit Today:

Past Surgical History

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Family Health History

	Age	Significant Health Problems		Age	Significant Health Problems
Father			**Child 1**		
Mother			**Child 2**		
Sibling's			**Child 3**		

HEALTH HABITS

Do you smoke?	● **Yes/ No**	**Do you use recreational drugs?**	● **Yes/No**
Do you consume alcohol?	**Yes/No**	**Do you consume caffeine?**	● **Yes/No**

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____

Rush Neurology, LLC

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Medication and Allergy Form

MEDICATIONS: *List all medications you are currently taking, along with dose and frequency*	**ALLERGIES** *List all medications that your are allergic to*

PHARMACY NAME/LOCATION	**PHARMACY PHONE:**

PLEASE READ AND SIGN

To the best of my ability I have listed all medications prescribed to me by healthcare providers. I understand that it is my responsibility to update Rush Neurology , LLC of all changes in medication. I also understand that prescriptions from Rush Neurology, LLC can only be filled when taken on schedule and that all refills must be requested through the pharmacy (if applicable). Additionally, I understand that failure to comply with these medication guidelines will automatically result in the cancellation of any and all refills.

Patient Signature: _____ **Date:** _____

Rush Neurology, LLC
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Consent to the use and disclosure of health information for treatment, payment or healthcare operation.

I, _____, understand that as a part of my healthcare, that Rush Neurology,LLC originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care and treatment. I understand that this information serves as:

- A basis of planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that upon request, I will be given a NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation. I understand that I have a right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept the terms of this consent.

_____ _____

Signature Date