Neurology Center, Inc.

Darshan Mahajan, M.D.
Diplomate, American Board of Psychiatry & Neurology
Electroencephalography & Neurophysiology

Supriya M. Mahajan, M.D.
Diplomate, American Board of Psychiatry & Neurology
Board Certified in Behavioral Neurology with specialization in Memory Disorders

Debabrata Ghosh, M.D., D.M.
Board Certified in Child Neurology,
American Board of Psychiatry & Neurology
Board Certified in Electrodiagnostic Medicine

Enclosed please find a patient information form to be completed and brought with you the day of your appointment. Be sure to sign where indicated.

You are asked to bring a list of your medications, the dosage and how you are taking them.

If recent testing has been done (labs, x-rays, MRI, CT scan), please bring a copy of these with you as well as the **ACTUAL FILMS AND/OR DISC.** This will eliminate duplicate testing being ordered, plus the doctor likes to review the actual films while you are here for your appointment.

If your insurance requires a co-payment, this will be payable the **DAY OF YOUR VISIT**, before you are put into an examination room. **Please be sure to bring copies of your current insurance cards** so that we can copy them on each visit.

If your insurance requires a referral form, it is **YOUR RESPONSIBILITY** to make sure that the referral form is here or you may bring it with you the day of your appointment. **IF NO REFERRAL, YOUR APPOINTMENT WILL BE RESCHEDULED**.

If you **DO NOT have any insurance coverage**, payment in full is expected the day of your visit. Failure to comply with the above will only delay your appointment, as it may be necessary to reschedule.

Thank you for your cooperation.

Neurology Center, Inc.

Main Office:
673 East River St.
Elyria, Ohio 44035
(440) 323-6422
FAX (440) 323-8149
FAX (440) 322-5574

3600 Kolbe Road, Suite 208
Lorain, Ohio 44053
(440) 989-6422
FAX (440) 323-8149
FAX (440) 322-5574

NEUROLOGY CENTER, INC.

PERSONAL INFORMATION

Patient's Legal Name_____

Date Of Birth _____ / _____ / _____ **Social Security#** _____ /_____ / _____

Address_____

City_____ **State** _____ **Zip** _____

Home Phone# (_____) _____-_____ **Cell Phone#** (_____) _____-_____

Married[ ] Divorced[ ] Widowed[ ] Single[ ] Separated[ ] Other _____

Sex _____ **Age** _____ **Birth Place**_____

Race: Afro-American [ ] Caucasian [ ] Hispanic[ ] Other_____

Family Doctor_____ **Referring Doctor**_____

Spouse's Name_____ **Spouse's Phone Number** (_____) _____ - _____

Patients Employer _____

Employer Address_____

City _____ **State** _____ **Zip** _____ **Phone** (_____) _____ - _____

Email _____ **@** _____ • _____

PHARMACY INFORMATION

Pharmacy _____ **City** _____ **Location** _____

INSURANCE

Policy Holder: [ ] Patient [ ] Spouse [ ] _____

Primary Holder Name_____

DOB ____/____/____ **Social Security #** _____ / _____ / _____ **Address : [ ] same as patients**

_____ **City** _____ **State** _____ **Zip** _____

EMERGENCY CONTACT (OTHER THAN SPOUSE) Name _____

Relationship to patient:_____ **Home Phone #** (_____) _____ -_____

Cell Phone# (_____) _____ - _____ **Address:** _____

City _____ **State** _____ **Zip** _____

PATIENT SIGNATURE X _____ **Date** _____ / _____ / _____

PATIENT NAME _____

left-handed ___ / right-handed ___ / ambidextrous ___

MEDICATIONS YOU ARE TAKING AT PRESENT: Milligrams and Directions _____

_____

_____

Are you taking aspirin? Y/N Vitamins _____ Birth Control Pills _____

Allergies to DRUGS : _____

Non-Drug Allergies:_____

Any sleep problems? Y / N Snoring Y / N Apnea Y / N

PAST MEDICAL ILLNESSES AND DATES: _____

SURGERIES: what, where , when, why : _____

_____

PATIENT HISTORY : diabetes ___ peptic ulcer disease ___ coronary artery disease ___ pacemaker ___ AICD ___ heart attack ___ hypertension ___ hyperlipidemia ___ head injury ___ fainting spells ___ thyroid problems ___ arthritis ___ lupus ___ cancer ___ sarcoidosis ___ stroke ___ osteoporosis ___ COVID ___ ADHD ____ other _____

R.O.S. :

APPETITE good ___ poor ___ average ___ **BLADDER HABITS** normal ___ irregular ___ **BOWEL HABITS** normal ___ irregular ___

LAST EXAM DATE: breast/mammogram _____ gynecological _____ prostate _____

Have you ever had HEPATITIS? _____ Do you have AIDS ?_____

Any **RECENT** changes in personality _____ memory _____ weight (loss or gain) _____ Are you pregnant? Y / N

Children (how many boys and girls. And what are their ages) _____

SMOKING: never ____ quit ____ when ____ yes ____ How much? cigarettes _____ chew _____ electronic _____

DRINKING: never ____ quit ____ when ____ yes _____ How much? social _____ alcohol _____ beer _____ other _____

CAFFEINE: never _____ quit _____ when ____ yes ____ How much? coffee _____ tea ____ soda ____ energy drinks ____

DRUG ABUSE: never ____ quit ____ when _____ yes ____ How much and what type ? _____

FAMILY HISTORY: (as in Mother, Father, Brother, Sister) ADHD ____ aneurysm ____ diabetes ____ epilepsy ____ headaches ____ heart disease ____ hypertension ____ migraines ____ Parkinson's disease ____ stroke ____ tremors ____

other : _____

TO FURTHER PROTECT YOUR CONFIDENTIALITY IN OUR OFFICE, PLEASE COMPLETE THE FOLLOWING QUESTIONS.

Can we leave a message on your voicemail/answering machine? Yes / No

Can we call you at work? Yes / No number (____) _____ - _____

If you are not at home are we permitted to leave a message for you with the person answering your telephone? Yes / No

Can we release medical information to your husband/wife, companion, or adult children? Yes / No

List any family members that you **DO NO WANT ANY INFORMATION RELEASED TO**:

_____

_____

_____

PATIENT NAME PRINTED _____

PATIENT SIGNATURE _____

DATE _____ (Authorization expires one year from this date)

INSURANCE INFORMATION

I have no insurance. I know I am financially responsible for all charges. **X** _____

Please present your insurance cards to the receptionist so that an accurate copy of our insurance information may be copied and place in your file. We ask for these each visit to insure up to date information.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize NEUROLOGY CENTER, INC. may release medical information requested by my insurance company for the purpose of processing my insurance claim on any and all charges by its office.

X _____ _____ / _____ / _____

Signature of Responsible Party Date (expires in one year of date)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my insurance benefits to be paid directly to NEUROLOGY CENTER, INC. and I understand that I AM FINANCIALLY RESPONSIBLE for all medical charges and non-covered services.

X _____ _____ / _____ / _____

Signature of Responsible Party Date (expires in one year of date)

Do you have a Living Will? Y / N If yes, who has a copy _____

Name Relationship to Patient

Neurology Center, Inc.

INSURANCE COPAYMENTS

Effective January 1, 2017, all patients whose insurance plan requires a **co-payment will be responsible for paying that copayment on the date of the office visit, no exceptions.** It is the responsibility of the patient and/or insured to know the obligations of their insurance plan that they participate in. We do accept Visa and Mastercard in the event you are unable to pay by cash or check. **If no co-payment can be made, your appointment will be rescheduled.**

_____

Patient and/or Insured

_____

Date

REFERRALS

Effective January 1, 2017. It is the **responsibility of the patient and/or insured to make sure that they have a current referral form necessary for their office visit, no exceptions,** It is the patient's and/or insurer's responsibility to know the obligations of the insurance plan they participate in. **If you DO NOT have a referral, your appointment will be rescheduled.**

_____

Patient and/or Insured

_____

Date

Neurology Center, Inc.

NO SHOW CHARGE

THERE WILL BE A CHARGE OF $40.00 TO ANY PATIENT THAT DOES NOT NOTIFY THE OFFICE 24 HOURS IN ADVANCE OF NOT BEING ABLE TO KEEP THEIR APPOINTMENT.

THE CHARGE IS FOR ADMINISTRATION, PREPARING OF CHARTS AND MAILING.

IF YOU HAVE A VALID REASON FOR NOT KEEPING YOUR APPOINTMENT, LET US KNOW AND IT WILL BE OUR DISCRETION IF YOU WILL BE CHARGED.

_____

PATIENT SIGNATURE DATE

THANK YOU FOR YOUR COOPERATION

NEUROLOGY CENTER, INC.

HEALTH QUESTIONNAIRE

Patient Name _____ DOB _____ / _____ / _____ Date ____ / _____ / _____

Dates may be approximate

1. Date of last visit with your primary care physician _____ / _____ / _____ ( ) N/A
2. Date of last visit by a cardiologist _____ / _____ / _____ ( ) N/A
3. Date of last eye exam by an eye doctor _____ / _____ / _____ ( ) N/A
4. Date of last HIV screening _____ / _____ / _____ ( ) N/A
5. Date of last colonoscopy _____ / _____ / _____ ( ) N/A
6. Date of last mammogram _____ / _____ / _____ ( ) N/A
7. Date of last OB/GYN exam _____ / _____ / _____ ( ) N/A
8. Date of last prostate exam _____ / _____ / _____ ( ) N/A
9. Date of last flu vaccine _____ / _____ / _____ ( ) N/A
10. Date of last pneumonia vaccine _____ / _____ / _____ ( ) N/A
11. Date of last tetanus vaccine _____ / _____ / _____ ( ) N/A

NEUROLOGY CENTER, INC.

BENEFIT OF NOTICE OF PRIVACY PRACTICING

WRITTEN ACKNOWLEDGEMENT FORM.

I,_____, HAVE RECEIVED A COPY OF

(Print your name)

NEUROLOGY CENTER'S NOTICE OF PRIVACY PRACTICES.

_____ _____

Signature of Patient Date