LINDA PAO, MD PA
Comprehensive Neurological Care

601 University Blvd. Suite 102
Jupiter, FL 33458

Patient Register

Name: _____

Age: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Alternate Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Male: ◯ Female: ◯

Social Security #_____ Birth date:_____

Occupation:_____ Employer:_____

Email:_____ WorkPhone:_____

*By providing your email you are authorizing us to register you in our patient portal.

Single: ◯ Married: ◯ Divorced: ◯ Widowed: ◯

Who referred you to our office? _____

Emergency Contact

Emergency Contact Person: _____

Tel:_____ Relations: _____

Is this person Power of Attorney and/or Health Care Surrogate? _____

Medical History

Please answer the following to the best of your ability.

Allergies: _____

Reason for visit: _____

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	Yes	No
Hypertension	○	○
Heart Disease	○	○
Depression	○	○
Thyroid Disease	○	○
Stroke (CVA) Year	○	○
Diabetes	○	○
Seizures/Epilepsy	○	○
Bone or Joint Disease	○	○

	Yes	No
Do/ Did you smoke? Quit:	○	○
Do/ Did you drink alcohol? Quit:	○	○
Do you drink caffeine?	○	○

List all medications that you are taking: _____

_____

_____

Please list anything that you are allergic to:

_____

_____

Your Current Health Status

On a scale of 1-10 rate your current state of health: (1=poor/ 10=excellent) _____

List your chief complaints in order of severity:

_____ For how long: _____

_____ For how long: _____

_____ For how long: _____

Patient's or Authorized Person's Signature- I authorize Linda Pao, MD to release any information acquired in the course of my treatment to my insurance company.

Signature:_____ Date:_____

Please Check All That Apply

Please check all symptoms you have ever had, even if they don't seem related to your current problem.

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☐ Headaches	☐ Pins and needle in legs	☐ Fainting	☐ Neck Pain
☐ Pins and needles in arms	☐ Back pain	☐ Loss of balance	☐ Dizziness
☐ Ringing in the ears	☐ Nervousness	☐ Numbness in fingers	☐ Tension
☐ Numbness in toes	☐ Upset Stomach	☐ Frequent colds	☐ Fatigue
☐ Depression	☐ Irritability	☐ Sleeping problems	☐ Stiff neck
☐ Cold hands or feet	☐ Heart burn	☐ Lack of concentration	☐ Mood swings
☐ Menstrual problems	☐ Prostate problems	☐ Chronic fatigue	☐ Diabetes
☐ Inability to lose weight	☐ Cardiovascular disease	☐ High blood pressure	☐ Asthma
☐ Arthritis	☐ Bladder problems	☐ Bronchitis	☐ Whiplash
☐ Carpal tunnel syndrome	☐ Colon problems	☐ Disc problems	☐ Migraines

Family History

At our office we are not only interested in your health and well-being, but also the health and well-being of your family. Please answer the questions below:

Mother living?	Yes ◯	No ◯	died at age _____	due to _____
Father living?	Yes ◯	No ◯	died at age _____	due to _____
Brother living?	Yes ◯	No ◯	died at age _____	due to _____
Sister living?	Yes ◯	No ◯	died at age _____	due to _____

Your Wellness Profile

	Yes	No
Do you belong to a health club/gym?	◯	◯
Do you take vitamins?	◯	◯
Do you take Aspirin?	◯	◯
Have you had a colonoscopy?	◯	◯

HIPPA Privacy Signature

I understand that, under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up -among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third -party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

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I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at their address to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide my such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. I have reviewed and understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

(Print)_____

Signature:_____ Date: _____

Informed Consent for Medical Care

I authorize: Linda Pao, MD to use and disclose a copy of health and medical information if I am unable to communicate to the following:

Name of Recipient: _____ Phone: _____

Name of Recipient: _____ Phone: _____

Signature _____ Date _____

Health Insurance

PAYMENT IS DUE AS SERVICES ARE RENDERED

Patients are responsible for payment at the time of their visit. Understand that health insurance policies are an arrangement between an insurance company and you. Dr. Pao is currently only participating with Medicare. All insurance cards and proof of I.D. must be presented at the time of treatment.

Patient's or Authorized Person's Signature-I authorize the release of any medical or other information necessary to my insurance carrier to process my claims. I am aware that Medicare may deny coverage of care and I agree to pay for services not covered by Medicare.

Signature _____ Date_____

Insurance company: _____ Policy #:_____

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Group #: _____ Insurance Phone: _____

Primary Policy Holder: _____

(If different from the patient)

Secondary Insurance: _____

ID#:_____ Group#:_____

Pharmacy: _____ Phone: _____