Patient Register

LINDA PAO, MD PA
Comprehensive Neurological Care

Date: _____

Name: _____

Date of birth _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Alternate Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Male: ☐ Female: ☐

Social Security # _____ Pharmacy: _____

Occupation: _____ Employer: _____

Email: _____ Work Phone: _____

*By providing your email you are authorizing us to register you in our patient portal. Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐

Primary Care Physician: _____ Phone: _____

Who referred you to our office? _____

Emergency Contact

Tel: _____ Relations: _____

Is this person Power of Attorney and/or Health Care Surrogate? Yes ☐ No ☐

Medical History

Reason for visit: _____

Medical History Continued

Please check all that apply

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- ☐ Hypertension
- ☐ Heart Disease
- ☐ Depression
- ☐ Thyroid Disease
- ☐ Stroke (CVA)
- ☐ Diabetes
- ☐ Seizures/
- ☐ Epilepsy
- ☐ Bone or Joint Disease
- ☐ Do/ Did you smoke? Quit:
- ☐ Do/ Did you drink alcohol?
- ☐ Do you drink caffeine?
- ☐ Anemia/Blood Disorder
- ☐ High Cholesterol
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Sleep Apnea
- ☐ Pacemaker/Defibrillator
- ☐ Head Injury
- ☐ Neuropathy
- ☐ Muscle Disorder
- ☐ Alcohol/Drug Dependency

Other _____

List all medications & supplements that you are taking: _____

_____

Please list anything that you are allergic to: _____

_____

Please list all surgeries and dates: _____

_____

_____

Please list any hospitalizations other than surgeries, including dates: _____

_____

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: _____

Current Weight: _____ Height: _____

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: _____

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Please Check All That Apply

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

- ☐ Headaches/Migraines
- ☐ Neck Pain/Pins and needles in arms
- ☐ Numbness in Fingers
- ☐ Blurred/Double Vision
- ☐ Sleeping Problems
- ☐ Lack of Concentration
- ☐ Chronic Fatigue
- ☐ Loss of Balance
- ☐ Bladder Problems
- ☐ Tremors
- ☐ Difficulty Swallowing
- ☐ Colon Problems
- ☐ Drooling
- ☐ Pain with Chewing
- ☐ Nervousness
- ☐ Upset Stomach
- ☐ Whiplash
- ☐ Snoring
- ☐ Pins and Needle in Legs
- ☐ Back Pain
- ☐ Dizziness
- ☐ Numbness Toes and /or Feet
- ☐ Depression
- ☐ Stiff Neck
- ☐ Mood Swings
- ☐ Inability to Lose/Gain Weight
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Prostate Problems
- ☐ Fainting
- ☐ Carpal Tunnel
- ☐ Irritability
- ☐ Heart Burn
- ☐ Joint Pain
- ☐ Ringing in Ears
- ☐ Others _____

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 ☐ due to _____
at age _____

Father living? Yes ☐ No ☐ due to _____
at age _____

Brother living? Yes ☐ No ☐ due to _____
at age _____

Sister living? Yes ☐ No ☐ due to _____
at age _____

Your Wellness Profile

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

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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.

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: _____

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Informed Consent for Medical Care

I authorize: Linda Pao, MD to use and disclose a copy of health andmedical informtion 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 #: _____ Group #: _____

Primary Policy Holder: _____
(If different from the patient)

Secondary Insurance: _____

ID#: _____ Group#: _____

Pharmacy: _____

LINDA PAO, MD PA

601 UNIVERSITY BLVD. SUITE 102
JUPITER, FL 33458
PHONE: (561)-444-3335
FAX: (561)-429-5934

****RELEASE OF MEDICAL RECORDS****

DATE: _____ **PATIENT:** _____

DOB: _____ **TO:** _____

FAX: _____

I, _____(Patient Name) release all of my Medical Records, including laboratory, radiology, neuro-diagnostic reports, consults, history, and follow up visit reports to **Linda Pao, MD PA.**

Please: ☐ MAIL and/or ☐ FAX the following:

- ☐ Initial Consultations and Follow-up visits
- ☐ ALL MRI's, CT's, EEG, EMG, Laboratory results within 1 year
- ☐ Carotid Doppler reports and Echocardiogram Reports
- ☐ Hospital H&P and Discharge Summaries

Other: _____

PATIENT SIGNATURE: _____

Submit