GUADALUPE REGIONAL MEDICAL GROUP

Neurology Associates

Andrew Cichowski, M.D.

Patient Information

Name: _____ Date of Birth: _____
First *MI* *Last*

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Pharmacy: _____City_____ Phone#:_____

Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Widowed ❑ Legally Separated

Ethnicity: ❑ Caucasian ❑ Hispanic ❑ African-American ❑ Asian/Pacific-Islander ❑ Other _____

Employer: _____ Occupation: _____

Home Phone	Cell Phone	Work Phone
(_____) _____ - _____	(_____) _____ - _____	(_____) _____ - _____
❑ This is my preferred number	❑ This is my preferred number	❑ This is my preferred number
May we leave personal/medical information on your voicemail? ❑ Yes ❑ No	*May we leave personal/medical information on your voicemail?* ❑ Yes ❑ No	
	**I understand that a cellular phone is not a secure and private line.*	

Email: _____

Primary Emergency Contact	Secondary Emergency Contact
Please check box below indicating whether or not you would like to have this Primary Emergency Contact added as an authorized HIPAA contact.	Please check box below indicating whether or not you would like to have this Primary Emergency Contact added as an authorized HIPAA contact.
❑ I authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact.	❑ I authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact.
❑ I do **NOT** authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact.	❑ I do **NOT** authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact.
Name: _____	Name: _____
Home Phone: (_____) _____-_____	Home Phone: (_____) _____-_____
Work Phone: (_____) _____-_____	Work Phone: (_____) _____-_____
Relationship: ❑ Spouse ❑ Partner ❑ Sibling ❑ Parent ❑ Child ❑ Friend ❑ Other	Relationship: ❑ Spouse ❑ Partner ❑ Sibling ❑ Parent ❑ Child ❑ Friend ❑ Other
Primary Care Provider	**Referring Provider**
Name: _____	Name: _____

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Insurance Coverage

You must bring a photo I.D. and insurance card(s) on the day of your appointment.

Primary Insurance	Secondary Insurance
Carrier: _____ Policy #: _____ Group #: _____ ***Policy Holder's Name***: _____ Policy Holder's **date of birth**: _____ Relationship to policy holder: ❑ Self ❑ Spouse ❑ Other _____	❑ I do not have a secondary insurance Carrier: _____ Policy #: _____ Group #: _____ **Policy Holder's Name**: _____ Policy Holder's **date of birth**: _____ Relationship to policy holder: ❑ Self ❑ Spouse ❑ Other _____

By signing this form I authorize:

1. The release of any medical and/or other information necessary to process my claims.
2. Payment of medical benefits to my treating physician or supplier for services rendered by Guadalupe Regional Medical Group.
3. I am financially responsible for all charges not covered by my insurance.

_____ _____
Patient/Guardian Printed Name Date

_____
Patient/Guardian Signature

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Please describe the reason for your visit with us today: _____

_____

Past Medical History

☐ Alcohol/Drug Abuse	☐ Cancer: _____	☐ High Cholesterol	☐ Sleep Apnea
☐ Anemia	☐ Coronary Artery Disease	☐ Kidney Disease	☐ Stomach Problems
☐ Anxiety	☐ Depression	☐ Liver Disease	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ Lupus	☐
☐ Asthma	☐ Emphysema	☐ Osteoporosis	☐
☐ Bladder Problems	☐ Gout	☐ Pneumonia	☐
☐ Blood Clot	☐ Heart Attack	☐ Rheumatoid Arthritis	☐
☐ Blood Transfusion	☐ High Blood Pressure	☐ Seizures	☐

_____

_____

_____

_____

Surgical History

☐ Abdominal surgery	☐ Colonoscopy	☐ Cataract	☐ Hysterectomy
☐ Appendectomy	☐ Coronary Bypass	☐ Gallbladder removal	☐ Knee Surgery
☐ Back Surgery	☐ Coronary Stent	☐ Heart Surgery (other than coronary bypass)	☐ Neck Surgery
☐ Biopsy	☐ Stomach Endoscopy	☐ Hip surgery	☐ Other

_____

_____

_____

_____

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Social History

Do you drink alcohol?	❑ Yes	❑ No	If yes, per day _____ per week _____
Do you currently smoke?	❑ Yes	❑ No	If yes, how many per day _____
Are you interested in getting more information on quitting?	❑ Yes	❑ No	
Do you use recreational drugs?	❑ Yes	❑ No	

Family History

Please indicate any immediate blood relatives who has/had the following:

	Mother	Father	Brother	Sister	Children	G-Mother	G-Father
Heart disease / Heart attack							
High blood pressure							
Stroke							
Diabetes							
Cancer (type)							
Neurological disorders							
Seizure disorder							
Genetic disorder							
Developmental delay							
Physical deformity							

Allergies

Do you have allergies to any drugs? ❑ Yes ❑ No

List any allergies and reactions to medications: _____

_____

Current Medication Log

List all medications (prescribed or over the counter/herbal supplements) that you are currently taking:

Medication	Start Date	Dose/Frequency	Prescribing Doctor	Comments

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Have you recently been experiencing any of the following symptoms recently?

Constitutional symptoms:
- ❑ Fever
- ❑ Weight loss
- ❑ Extreme fatigue

Eyes:
- ❑ Double vision
- ❑ Sudden loss of vision

Ears, nose, mouth, and throat:
- ❑ Sore throat
- ❑ Runny nose
- ❑ Ear pain

Cardiovascular:
- ❑ Chest pain
- ❑ Palpitations
- ❑ Swelling of your feet

Respiratory:
- ❑ Cough
- ❑ Wheezing
- ❑ Shortness of breath

Gastrointestinal:
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Blood in stools

Genitourinary:
- ❑ Irregular menses
- ❑ Vaginal bleeding after menopause
- ❑ Frequent or painful urination
- ❑ Bloody urine
- ❑ Testicular pain of pass

Skin:
- ❑ Rash
- ❑ Changing mole

Neurological:
- ❑ Headache
- ❑ Persistent weakness
- ❑ Falling

Musculoskeletal:
- ❑ Joint pain
- ❑ Muscle pain

Psychiatric:
- ❑ Depression
- ❑ Anxiety
- ❑ Suicidal thoughts

Endocrine:
- ❑ Excessive thirst
- ❑ Cold or heat tolerance
- ❑ Breast mass

Hematologic:
- ❑ Unusual bruising or bleeding
- ❑ Enlarged lymph nodes

Allergic:
- ❑ Hay fever

OFFICE & FINANCIAL POLICIES

Please initial by each number:

_____1. **PAYMENTS.** We require payment in full for any amounts designated to be the patient's responsibility at the time services are rendered. This may include co-pays, co-insurance, and/or deductible amounts. For returned checks, there will be a $25 charge and future payments will be required to be paid with cash, a money order, or a credit card.

_____2. **APPOINTMENT CANCELLATION.** All appointments must be rescheduled or cancelled 24 hours before your scheduled appointment. You will be charged a $25 fee for missed appointments, cancellations or rescheduled appointments less than 24 hours, unless you had an emergency.

_____3. **HMO & PPO REFERRALS.** If your insurance policy requires written authorization (referrals or precertification) from your referring physician, we require this authorization be on file at the time of your appointment. It is your responsibility to make sure that your visit is pre-approved so that your insurance company will pay for your visit. Otherwise you will be responsible for the payment in full.

_____4. **MEDICATION REFILL REQUEST.** Please allow 24 to 48 hours to refill your medication(s). If your medication refill has expired you will need to schedule an appointment.

_____5. **TEST RESULTS.** Test results will not be given over the phone and an appointment will be made to review results.

_____6. **15 MINUTE LATE POLICY.** Please arrive 10 minutes before your scheduled appointment in order to be processed. If you are not here at the requested time before your appointment, we may have to delay or reschedule your visit.

_____7. **CHRONIC CARE MANAGEMENT.** (For patients 65+) I understand Chronic Care Management services are subject to the usual Medicare deductible and coinsurance. I hereby indicate by signature that Dr. Sangha is designated as my primary care physician for purposes of providing Medicare chronic care management. This designation is effective as of the date below and remains in effect until revoked in writing by me. If revoked, this will result in limited services outside of a clinic visit.

_____8. **NON-COVERED SERVICES.** I understand some services may *not* be a covered benefit under my medical policy (weight loss, obesity, mental health {depression, anxiety, Insomnia, post-traumatic stress disorder}, and erectile dysfunction) and that my health insurance coverage has certain restrictions and limitations. If non-covered services are provided, I understand and agree to be financially responsible for any and all charges related to these services. I also understand that my account balance must be current to receive refills for medications prescribed by my Health-Care Provider.

"I, the guarantor of payment and responsible party, agree to the above policies and agree to the terms."

Signature of Patient: _____ **Date**: _____

Printed Name: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, have read the Guadalupe Regional Medical Group Notice of Privacy Practices. By signing, I acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices and HIPAA Consent and agree to all provisions outlined herein and I give permission to GRMG to obtain my Medication History from my pharmacy, my health plan, or other healthcare provider.

Signature of Patient: _____ **Date**: _____

I give permission to GRMG to release my private information to the following person(s). Please print below:

_____ _____ _____

GUADALUPE REGIONAL MEDICAL GROUP

Prescription History Consent

I voluntarily consent to provide Guadalupe Regional Medical Group (GRMG) access to, and use of, my prescription medication history from other healthcare providers or third-party pharmacy benefits payors for treatment purposes. I understand that my prescription history (which included, but is not limited to, prescriptions, labs, and other healthcare drug historical information) from multiple other independent medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that GRMG may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that the ***Prescription History Consent*** will be valid and will remain in effect as long as I receive services from GRMG, unless revoked by me in writing.

Notice of Privacy Practices

I acknowledge that GRMG Notice of Privacy Practices provides information about how the practice and its staff may use and/or disclose protected-health information about me for treatment, payment, health-care operations, and as otherwise allowed by law. I understand that GRMG is not responsible for use or re-disclosure of information by third parties.

I certify that I have read this form or it has been read to me.

_____	_____	_____
Patient's DOB	Print Patient's Name	Date

	_____	_____
	Signature of Patient or Legally Authorized Representative	Relationship to Patient

For patients requiring translation or verbal reading of this document, the person reading or translating should sign and date below.

Reader or Translator Signature: _____ Date: _____