Methodist Sugar Land Neurology Associates
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Board Certified in Adult Neurology

We appreciate the trust placed in us to provide your specialty care. The following information clarifies our respective responsibilities in providing and receiving information. Our patient care procedures have been developed over time to maximize your visit experience and outcome.

New Patients: New patients are usually referred to us by their primary care physician or other specialist. If you have received diagnostic testing of any kind (x-ray, MRI, CT, laboratory) related to this visit, please bring the test results with you or have them forwarded to us prior to your visit.

If you are insured with an HMO, your primary care physician will provide a written referral that includes their diagnosis for referral. Without a referral, we will not be able to bill your insurance and you may be asked to pay in full at the time of the visit.

Please bring the following to your visit:

- Written referral – HMO insurance only
- Results of tests ordered by referring MD
- New patient forms
- Insurance card
- Photo ID

Appointments: We attempt to contact patients 24-48 hour prior to their appointment. Our schedule is usually booked several weeks in advance, so we ask for at least 1 business day notice for cancellation. Failure to notify our office of cancellation at least one full business day prior to your scheduled appointment or not appearing for your scheduled appointment may result in a No Show Charge.

Test Results: Test results are given during a follow up visit only. You will be asked to schedule an appointment to discuss results of any tests ordered by our physicians to avoid misunderstandings and improve the patient care outcome. Please do not contact the office for a copy, fax, or verbal disclosure prior to your follow up appointment. **NOTE**: You will be contacted should any result require action prior to your scheduled follow up appointment.

Forms: Your primary care physician will complete disability, FMLA, or functional capacity evaluation forms.

Refills: Medications prescribed by our physicians may be refilled if you have been seen within the last year. Refills will not be approved after office hours or on weekends. We do not call mail order pharmacies as they require a written prescription.

Methodist Sugar Land Neurology Associates

PAST MEDICAL HISTORY
COMPLETE IN DETAIL

SURGICAL HISTORY *(CHECK BOXES THAT APPLY TO YOUR PAST SURGICAL HISTORY)*

☐ Appendectomy ☐ Cataract ☐ Gyn Surgery ☐ Gallbladder ☐ Tonsillectomy ☐ Hernia ☐ Heart Surgery
☐ Pacemaker ☐ Other Surgeries:_____

MEDICAL HISTORY *(CHECK BOXES THAT APPLY TO YOUR PAST MEDICAL HISTORY)*

☐ High Blood Pressure ☐ Diabetes ☐ Seizures ☐ Heart Disease ☐ Migraine ☐ Stroke
☐ Thyroid Disease ☐ High Cholesterol
☐ Cancer (Type of Cancer)_____
☐ Other Medical or Neurological Problems_____

CURRENT MEDICATIONS & DOSAGE *please complete in detail*

SOCIAL HISTORY

Smoking? ☐ No ☐ Yes (If yes, please list how many packs per day and for how many years you have smoked)
____Packs per day for ____ year(s). Date Quit Smoking_____

Alcohol? ☐ No ☐ Yes (If yes, please indicate the number of drinks per day, number of years, and type(s) of alcohol used)
_____drink(s) per day for ____year(s). Type(s) of drinks ☐ Beer ☐ Wine ☐ Mixed Drinks
☐ Never used alcohol ☐ Hospitalized for alcohol use

EMPLOYMENT Job Title_____

Exposures: ☐ Noise ☐ Chemicals ☐ Toxins ☐ Fumes ☐ Gases

EDUCATION Highest level Achieved_____

FAMILY HISTORY *(please list those people in your family with the following illnesses):*

High Blood Pressure: _____
Diabetes: _____
Stroke: _____
Seizures: _____
Alzheimer's: _____
Heart Disease: _____
Cancer: _____
Migraine: _____
Parkinson's: _____
Other Neurological Problems:
_____

Patient Name: _____ Date: _____

Patient Symptoms

Constitutional Symptoms			If Yes, please explain
Good general health lately:	☐ No	☐ Yes	_____
Recent weight change:	☐ No	☐ Yes	_____
Fever:	☐ No	☐ Yes	_____
Fatigue:	☐ No	☐ Yes	_____
Headaches:	☐ No	☐ Yes	_____
Eyes			
Eye disease or injury:	☐ No	☐ Yes	_____
Wear glasses / contact lens:	☐ No	☐ Yes	_____
Blurred or double vision:	☐ No	☐ Yes	_____
Glaucoma:	☐ No	☐ Yes	_____
ENT			
Hearing loss or ringing:	☐ No	☐ Yes	_____
Nose bleeds:	☐ No	☐ Yes	_____
Swollen glands in neck:	☐ No	☐ Yes	_____
Cardiovascular			
Heart trouble:	☐ No	☐ Yes	_____
Chest pain or angina pectoris:	☐ No	☐ Yes	_____
Palpitation:	☐ No	☐ Yes	_____
Shortness of breath with walking or laying flat:	☐ No	☐ Yes	_____
Swelling of feet, ankles or hands:	☐ No	☐ Yes	_____
Respiratory			
Chronic or frequent coughs:	☐ No	☐ Yes	_____
Spitting up blood:	☐ No	☐ Yes	_____
Shortness of breath:	☐ No	☐ Yes	_____
Asthma or wheezing:	☐ No	☐ Yes	_____
Gastrointestinal			
Change in bowel movements:	☐ No	☐ Yes	_____
Nausea or vomiting:	☐ No	☐ Yes	_____
Rectal bleeding or blood in stool:	☐ No	☐ Yes	_____
Abdominal pain or heartburn:	☐ No	☐ Yes	_____
Peptic ulcer (stomach or duodenal):	☐ No	☐ Yes	_____
Genitourinary			
Frequent urination:	☐ No	☐ Yes	_____
Burning or painful urination:	☐ No	☐ Yes	_____
Blood in urine:	☐ No	☐ Yes	_____
Incontinence or dribbling:	☐ No	☐ Yes	_____
Kidney stones:	☐ No	☐ Yes	_____

Patient Name:_____ Date:_____

Patient Symptoms (cont.)

			If Yes, please explain
Musculoskeletal			
Joint pain:	☐ No	☐ Yes	_____
Joint stiffness or swelling:	☐ No	☐ Yes	_____
Weakness of muscles or joints:	☐ No	☐ Yes	_____
Muscle pain or cramps:	☐ No	☐ Yes	_____
Back pain:	☐ No	☐ Yes	_____
Cold extremities:	☐ No	☐ Yes	_____
Difficulty in walking:	☐ No	☐ Yes	_____
Integumentary (skin)			
Rash or itching:	☐ No	☐ Yes	_____
Change in skin color:	☐ No	☐ Yes	_____
Varicose veins:	☐ No	☐ Yes	_____
Neurological			
Frequent or recurring headaches:	☐ No	☐ Yes	_____
Lightheaded or dizzy:	☐ No	☐ Yes	_____
Convulsions or seizures:	☐ No	☐ Yes	_____
Numbness or tingling sensations:	☐ No	☐ Yes	_____
Psychiatric			
Memory loss or confusion:	☐ No	☐ Yes	_____
Nervousness:	☐ No	☐ Yes	_____
Depression:	☐ No	☐ Yes	_____
Insomnia:	☐ No	☐ Yes	_____
Endocrine			
Excessive thirst or urination:	☐ No	☐ Yes	_____
Heat or cold intolerance:	☐ No	☐ Yes	_____
Psychiatric			
Bleeding or bruising tendency:	☐ No	☐ Yes	_____
Anemia:	☐ No	☐ Yes	_____
Phlebitis:	☐ No	☐ Yes	_____
Past transfusion:	☐ No	☐ Yes	_____

Allergies: History or Reaction to Medicines or Other Agents

Penicillin: ☐ No ☐ Yes

Other antibiotics: ☐ No ☐ Yes (list): _____

Morphine, Demerol, or other narcotics: ☐ No ☐ Yes

Novocain or other anesthetics: ☐ No ☐ Yes

Aspirin or other pain remedies: ☐ No ☐ Yes

Iodine, methiolate or other antiseptic: ☐ No ☐ Yes

Tetanus antitoxin or other serums: ☐ No ☐ Yes

Other drugs / medications: _____

Patient Name: _____ Date: _____

PATIENT INFORMATION
COMPLETE FORM IN DETAIL

Patient's Name_____Date of Birth _____ Sex_____
(MM/DD/YYYY)

Home Address_____
(No P. O. Boxes) (Street, Apt. #) (City) (State) (Zip)

Phone: Home # _____ Cell # _____

SS#_____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name _____Work # _____Cell#_____

Emergency Contact _____Relation_____Daytime Phone # _____
(OTHER THAN SPOUSE)

Address_____City_____State_____Zip_____

Who is your Primary Care Doctor?

Name _____

Address_____

Phone # _____

Referring Physician (if not your PCP)

Name _____

Address_____

Phone # _____

INSURANCE INFORMATION

CURRENT VALID INSURANCE CARDS AND A PHOTO ID MUST BE PROVIDED

Is this a worker's compensation claim? ☐ ***Yes*** ☐ ***No*** ***Is this related in any way to an accident/injury?*** ☐ ***Yes*** ☐ ***No***

Primary Insurance:_____ ☐ PPO ☐ HMO ☐ POS

Subscriber name: (Last)_____(First)_____(MI)_____DOB_____

☐ Self ☐ Spouse ☐ Parent ☐ Other ID No._____ Group No._____

Secondary Insurance:_____ ☐ PPO ☐ HMO ☐ POS

Subscriber name: (Last)_____(First)_____(MI)_____DOB_____

☐ Self ☐ Spouse ☐ Parent ☐ Other ID No._____ Group No._____

I understand that I am responsible for my bill. I authorize Methodist Sugar Land Neurology Associates to act as my agent in helping me obtain payment from my insurance company/companies. I authorize payment directly to Methodist Sugar Land Neurology Associates. I authorize release of information necessary to collect payments to all my insurance companies. I further authorize release of medical information to any and all physicians involved in my care. I permit a copy of this authorization to be used in place of the original. I authorize the use of the "Signature on File" to be used on all my insurance submissions. I understand that I am responsible for notifying the office of any Precertification or referral needed for my insurance.

Signature of Patient or Guardian: _____ Date: _____

Methodist The Methodist Hospital
Physician Organization

MEDICARE STATUS QUESTIONNAIRE

Is Medicare primary or secondary insurance for your visit today?

Dear Medicare Patient:

As a direct result of Medicare regulations, we are required to gather the following information to determine if Medicare is your primary insurance for your visit today.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

1. Is your appointment today due to an accident? ☒ YES ☐ NO

   If yes, was the accident ☐ work related or ☐ non work related? (Please check one)

2. Are you receiving Black Lung Benefits? ☐ YES ☐ NO

3. Has the Department of Veterans Affairs authorized and agreed to pay for care given to you by the Methodist Sugar Land Neurology? ☐ YES ☐ NO

4. Are the services for which you are seeing the doctor today covered by a government program such as a research grant? ☐ YES ☐ NO

5. Are you covered by any Employer Group Health Plan, including Federal Employee Health Benefits or any retirement policy? ☐ YES ☐ NO

   If so, please provide the following information:

   Policy #: _____ Group #: _____

   Insurance Plan or Name: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Name of Policy Holder: _____ Relationship to you: _____

   Is policy holder currently employed? ☐ Yes ☐ No

   If yes, number of employees employed by employer:

   ☐ Less than 20 ☐ 20 or more ☐ Less than 100 ☐ More than 100

6. Are you entitled to Medicare based on: (Please check all that apply)
   - ☐ Age
   - ☐ Disability
   - ☐ End Stage Renal Disease

Date	Initials

Date	Initials

Date	Initials