

## Penn-Tampa Neurology

Thomas O. Pearson, MD - Certified by the American Board of Neurology

# New Patient Registration Form

Patient name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City/state/zip code)

Home phone: (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_ Cell phone: (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: [M] [F] [other: \_\_\_\_\_]

Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Email address: \_\_\_\_\_

Would you like to receive email communication from our office? ☐ Yes ☐ No

Ethnicity: \_\_\_\_\_ Primary Language Spoken: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

### Emergency Contact OR Primary Contact Information (other than patient):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone 1: (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_ Phone 2: (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

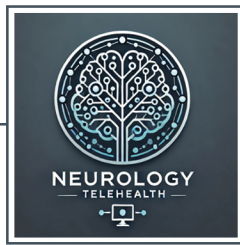
Address: \_\_\_\_\_  
(Street) (City/state/zip code)

### Person responsible for Payment: (complete only if different than patient)

Name: \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City/state/zip code)



### Insurance information

Primary insurance:

Plan name: \_\_\_\_\_ ID #: \_\_\_\_\_

Secondary insurance:

Plan name: \_\_\_\_\_ ID #: \_\_\_\_\_

Policy Holder Date of birth: \_\_\_\_\_ Effective date: \_\_\_\_\_

Is your visit related to a recent hospital stay or physician referral? ☐ Yes ☐ No

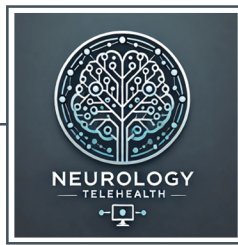
If so, please notify the office to check for medical records. Our fax #727-771-1816

I authorize the release of any medical information necessary to process this bill to my insurance company.

I acknowledge that I am financially responsible for payment, whether or not covered by insurance.

Co-payments are expected at time of visit.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Medical information

**Medical History** (for example: previous diagnosis, high blood pressure, diabetes, COPD, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**Current Medications:** Including supplements and over the counter medications

- |           |             |
|-----------|-------------|
| 1. _____  | Dose: _____ |
| 2. _____  | Dose: _____ |
| 3. _____  | Dose: _____ |
| 4. _____  | Dose: _____ |
| 5. _____  | Dose: _____ |
| 6. _____  | Dose: _____ |
| 7. _____  | Dose: _____ |
| 8. _____  | Dose: _____ |
| 9. _____  | Dose: _____ |
| 10. _____ | Dose: _____ |



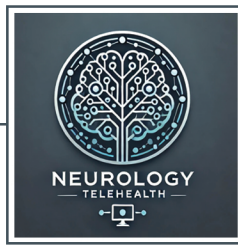
**Drug Allergies:**

1. \_\_\_\_\_ RXN: \_\_\_\_\_
2. \_\_\_\_\_ RXN: \_\_\_\_\_
3. \_\_\_\_\_ RXN: \_\_\_\_\_
4. \_\_\_\_\_ RXN: \_\_\_\_\_
5. \_\_\_\_\_ RXN: \_\_\_\_\_
6. \_\_\_\_\_ RXN: \_\_\_\_\_

**Past surgeries:**

1. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_
3. \_\_\_\_\_ Date: \_\_\_\_\_
4. \_\_\_\_\_ Date: \_\_\_\_\_
5. \_\_\_\_\_ Date: \_\_\_\_\_
6. \_\_\_\_\_ Date: \_\_\_\_\_

Reason for visit/referral: \_\_\_\_\_

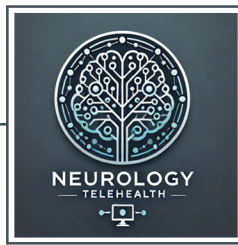


**Have you had any of these symptoms in the past?** Check those that apply

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Headache                         | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Loss of Consciousness   |
| <input type="checkbox"/> Confusion                        | <input type="checkbox"/> Concentration issues | <input type="checkbox"/> Memory loss             |
| <input type="checkbox"/> Speech difficulty                | <input type="checkbox"/> Personality change   | <input type="checkbox"/> Hallucinations          |
| <input type="checkbox"/> Seizures                         | <input type="checkbox"/> Stiffness            | <input type="checkbox"/> Clumsiness              |
| <input type="checkbox"/> Nausea                           | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Balance difficulty      |
| <input type="checkbox"/> Poor coordination                | <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Vertigo (room spinning) |
| <input type="checkbox"/> Hearing loss                     | <input type="checkbox"/> Trouble swallowing   | <input type="checkbox"/> Drooling                |
| <input type="checkbox"/> Loss of smell or taste           | <input type="checkbox"/> Hoarseness of voice  | <input type="checkbox"/> Weakness                |
| <input type="checkbox"/> Loss of bowel or bladder control | <input type="checkbox"/> Pain                 | <input type="checkbox"/> Vision change           |

**Family History** Check those that apply

	Father	Mother	Father's Parents	Mother's Parents	Children	Siblings
Heart Disease						
Hypertension						
Diabetes						
Cancer						
Bleeding disorder						
Stroke						
Migraines						
Movement disorder						
Muscle or nerve disorder						
Dementia						
Seizures						
Mental illness						
Other:						



## Social History

Place of Birth: \_\_\_\_\_ Years resided here: \_\_\_\_\_

Marital Status: [Single] [Married] [Divorced] [Separated] [Widowed]

Children? ☐ Yes ☐ No How many? \_\_\_\_\_ Ages: \_\_\_\_\_

Occupation: \_\_\_\_\_

Years of Education: \_\_\_\_\_

Handedness: [right handed] [left handed] [ambidextrous]

Tobacco use: ☐ Never smoker ☐ Former smoker Quit: \_\_\_\_\_

☐ Current smoker Packs per day: \_\_\_\_\_ Years: \_\_\_\_\_

Alcohol use: Amount: ☐ None ☐ 1-3 drinks ☐ 4-6 drinks ☐ 6+ drinks

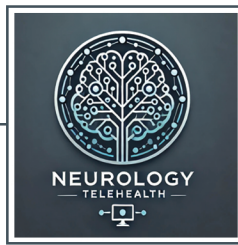
Frequency: ☐ Day ☐ Week ☐ Month ☐ Year

Past history: \_\_\_\_\_

Caffeine intake: \_\_\_\_\_

Do you have a living will? ☐ Yes ☐ No

Next of kin or health care surrogate: \_\_\_\_\_



## NO-SHOW POLICY

We are honored that you have chosen to obtain your care with Penn-Tampa Neurology, however, if you miss a scheduled visit, that compromises your care.

In addition, it compromises the care of patients who might have wanted to be seen during that time slot. Please provide us with 24-hour notice for cancellations.

1<sup>st</sup> event: we will call to reschedule you. You will be charged a \$35 fee

2<sup>nd</sup> event: we will call to reschedule you. You will be charged a \$35 fee

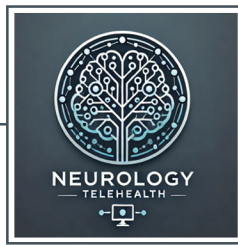
3<sup>rd</sup> event: you may be discharged from the practice. You will be charged a \$35 fee

Regarding diagnostic testing: when we schedule patients for diagnostic testing, we schedule the physician, reserve equipment, and often schedule a technologist. This is similar to what is involved with scheduling surgery. A no-show for diagnostic testing will be charged \$50, and unless there are extenuating circumstances, testing may not be rescheduled.

Our main concern is to provide you and the other patients in our practice with the best neurology care possible.

I \_\_\_\_\_ understand the missed appointments policy.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## FINANCIAL POLICY

Copays are due at the time of service.

Our billing management team is Healthcare Support Technologies, Inc.

They bill insurances first; balance billing for whatever insurance does not cover is invoiced to the patient twice on a monthly cycle over 60 days. The phone number, contact, and address for the billing company will be clearly see on invoices. Please communicate financial questions with them.

Please address outstanding bills on a timely basis, as we are much more interested in focusing on your healthcare needs than we are on following financial issues, which are viewed more as a necessary evil.

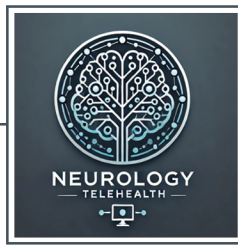
If the billing management team has no response from two billing cycles, the account is forwarded to a collections agency which is separate from our practice.

That agency charges us a fee of 30% of the balance for accounts with a balance less than \$1000, and a fee of 40% fee of the balance for accounts with a balance over \$1000.

That fee to us will be added to the balance when it is turned over to collections and will be the responsibility of the patient. Patients who habitually allow their accounts to remain unpaid will be discharged from the practice.

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_





## Authorization for Release of Medical Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_ SS#: \_\_\_\_\_

I authorize Dr. Pearson to release my information in my record to any medical practitioner, physician, hospital, medical institution or facility to which I may be referred to assist in my care.

I authorize Dr. Pearson to obtain any information any medical practitioner, physician, hospital, medical institution or facility to which I may be referred to assist in my care.

## Family & Friends

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

## PPO / HMO Patients Financial Responsibility

I understand that I am insured through an HMO /PPO I am. I understand that it is my responsibility to obtain the proper and necessary referrals from my primary care physician before seeing Dr. Pearson.

Although Dr. Pearson and his staff will make all reasonable efforts to assure that ordered testing is covered by my medical plan, I also understand that it is ultimately my responsibility to do so before having any testing or treatment.

I understand that I am fully and totally responsible for any fees rejected by my insurance carrier. I shall also be responsible for any appeals of such rejected claims.

I further agree to inform Dr. Pearson's office of any changes in my insurance coverage for carrier in a timely fashion.

I give permission for Dr. Pearson or his staff to leave a message on voicemail.

**Patient Signature:** \_\_\_\_\_