Penn-Tampa Neurology

Thomas 0. 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 that 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

☐ Headache	☐ Dizziness	☐ Loss of Consciousness
☐ Confusion	☐ Concentration issues	☐ Memory loss
☐ Speech difficulty	☐ Personality change	☐ Hallucinations
☐ Seizures	☐ Stiffness	☐ Clumsiness
☐ Nausea	☐ Vomiting	☐ Balance difficulty
☐ Poor coordination	☐ Ringing in ears	☐ Vertigo (room spinning)
☐ Hearing loss	☐ Trouble swallowing	☐ Drooling
☐ Loss of smell or taste	☐ Hoarseness of voice	☐ Weakness
☐ Loss of bowel or bladder control	☐ Pain	☐ 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 heath care surrogate: _____

NO-SHOW POLICY

We are honored that you have chosen to obtain your care with Penn-Tampa Neurology, however, if you muss 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.

1st event: we will call to reschedule you. You will be charged a $35 fee

2nd event: we will call to reschedule you. You will be charged a $35 fee

3rd 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 Ian. 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: _____