

Prafull K. Dave, M.D., P.A.

Adult & Child Neurology - EEG, EMG & Sleep Study Center
Fax: 301-263-7933

217 Washington Heights Medical Center
Westminster, MD 21157
410-848-9337

188 Thomas Johnson Drive, Suite 200
Frederick, MD 21702
301-695-6556

1101 Opal Court, Suite 213
Hagerstown, MD 21740
301-416-8199

PATIENT REGISTRATION (please print clearly)

FIRST NAME	MI	LAST NAME	AGE	DOB	SEX ☐ MALE ☐ FEMALE
ADDRESS		CITY	STATE	ZIP	☐ HOME ☐ CELL
EMPLOYER	ADDRESS			WORK PHONE	
OCCUPATION	SOCIAL SECURITY NO			MARITAL STATUS ☐ S ☐ M ☐ D ☐ W	
SPOUSE/PARENT NAME	SPOUSE/PARENT EMPLOYER			SPOUSE/PARENT PHONE	
NEAREST RELATIVE/FRIEND		RELATIONSHIP	HOME PHONE	CELL PHONE	

GENERAL MEDICAL INFORMATION

REFERRING PHYSICIAN	ADDRESS	PHONE NUMBER
FAMILY PHYSICIAN	ADDRESS	PHONE NUMBER
DESCRIBE CURRENT PROBLEM(S)		
DATE OF ONSET	FEMALES ONLY - POSSIBLE PREGNANCY? ☐ YES ☐ NO	

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	COPAY \$	DEDUCTIBLE \$	ID / POLICY NUMBER	GROUP #
ADDRESS	PHONE NO		SUBSCRIBER'S NAME	RELATIONSHIP
SECONDARY INSURANCE NAME	COPAY \$	DEDUCTIBLE \$	ID / POLICY NUMBER	GROUP #
ADDRESS	PHONE NO		SUBSCRIBER'S NAME	RELATIONSHIP
PLEASE NOTE THAT THERE IS A SEPARATE CHARGE FOR ANY DIAGNOSTIC TESTING IN ADDITION TO THE CHARGE OF THE CONSULTATION PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.				

ACCIDENT OR INJURY INFORMATION

CHECK ONE ☐ WORKER'S COMPENSATION (injured on the job) ☐ AUTO ACCIDENT		
DATE OF INJURY / ACCIDENT	CLAIM NO	EMPLOYER AT TIME OF INJURY / ACCIDENT
EMPLOYER'S ADDRESS	PHONE NO	CONTACT / PHONE NO
INSURANCE CO	ADDRESS	CONTACT / PHONE NO
ATTORNEY'S NAME	ADDRESS	CONTACT/PHONE
PLEASE NOTE WITHOUT PROPER AUTHORIZATION, ALL COSTS INCURRED MAY BECOME YOUR RESPONSIBILITY.		

ASSIGNMENT OF BENEFITS

I hereby authorize & direct you, my insurance company, and/or attorney, to pay directly to PRAFULL K DAVE, M.D. such sums as may be due and owing this office for services rendered me, both by reasons of accident or illness, and by reason of any other bills that are due in this office, and withhold such sums from any disability benefits, no-fault benefits, health and accident benefits or worker's compensation benefits or any other insurance benefits obligated to reimburse me from a settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I do hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds for any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated to said office. This is to act as a COMPLETE ASSIGNMENT OF MY RIGHTS & BENEFITS TO THE EXTENT OF THE OFFICE'S SERVICES PROVIDED.

I understand that I remain personally responsible for the total amounts due to this office for their services. I further understand and agree that this assignment, lien and authorization does not constitute any consideration for this office to await payments and they demand payments from me immediately upon rendering of services.

In the event my insurance company obligated to make payments to upon the charges made this office for their services refuses to make payments, I hereby assign transfer any and all causes of action that I might have or that exist in my favor against such company and authorize this office to prosecute said cause of action in my name or the office's name; and I further authorize this office to resolve such claims as they see fit.

I authorize release of any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this agreement.

I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

PATIENT CONSENT
ADDENDUM FOR HIPAA
EFFECTIVE 4/14/2003

I hereby authorize Prafull K. Dave, M.D. to apply for benefits on my behalf for covered services rendered by Dr. Dave. I request payment from my insurance company to be made directly to Dr. Dave. I certify that the information that I have reported with regard to my insurance coverage is correct and further consent to the release of any necessary information, including medical information for the purpose of treatment, payment and health care operations, for this or any related claims.

I acknowledge that a Notice of Privacy Practices is posted and available for viewing, and that a personal copy may be requested. I permit this consent to be used in place of the original, as accepted by law.

Patient Signature

Date

Parent/Guardian Signature (if patient is a minor)

Date

Attorney Signature

Date

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CHIEF COMPLAINT

PATIENT NAME _____

REASON FOR TODAY'S VISIT _____

PRIMARY DOCTOR _____ FAX # _____

PHARMACY NAME _____ CITY _____ STATE _____

EMAIL ADDRESS _____

HEIGHT: _____ WEIGHT _____

DO YOU HAVE AN ADVANCED DIRECTIVE: ☐ NO ☐ YES, EXPLAIN: _____

PLEASE LIST ANY MAJOR ILLNESSES AND OR INJURIES:

SURGERIES/HOSPITALIZATIONS	YEAR	COMPLICATION

CURRENT MEDICATION(S)	DOSE	FREQUENCY

LIST ANY TEST (RADIOLOGY/EEG/NCT) YOU HAVE HAD AND PROVIDE APPROXIMATE DATES

TYPE OF TEST	LOCATION	DATE

ALLERGIES TO ANY MEDICATIONS _____

BALANCE _____ PAID _____ CC CK CA POSTED Y N SCANNED _____

PATIENT NAME: _____

FAMILY MEMBER	ALIVE	DECEASED	AGE	HEALTH STATUS OR CAUSE OF DEATH
GRANDMOTHER (MOMS)	A	D	_____	_____
GRANDFATHER (MOMS)	A	D	_____	_____
GRANDMOTHER (DADS)	A	D	_____	_____
GRANDFATHER (DADS)	A	D	_____	_____
FATHER	A	D	_____	_____
MOTHER	A	D	_____	_____
SISTER/BROTHER	A	D	_____	_____
SISTER/BROTHER	A	D	_____	_____

SOCIAL HISTORY

OCCUPATION _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

DO YOU HAVE CHILDREN ☐ YES HOW MANY _____ ☐ NO

DO YOU LIVE ALONE ☐ YES ☐ NO WHO LIVES WITH YOU _____

DO YOU SMOKE ☐ YES I'VE SMOKED _____ PACKS OF CIGARETTES PER DAY FOR _____ YEARS SMOKE CIGARS OR PIPE

☐ NO, NEVER SMOKED NO, I QUIT _____ YEARS AGO. AT THAT TIME I WAS SMOKING _____ PACKS PER DAY FOR _____ YEARS

DO YOU DRINK ALCOHOL ☐ YES ☐ DAILY, 1 OR MORE TIMES A WEEK ☐ DAILY, 1 OR MORE TIMES A MONTH

☐ NO, NEVER OR RARELY ☐ NO, BUT I USED TO

ARE YOU AT RISK FOR AIDS (E.G. SEXUAL ORIENTATION, DRUG ABUSE, PREVIOUS BLOOD INFUSION) ☐ YES ☐ NO

PLEASE EXPLAIN: _____

REVIEW OF SYMPTOMS

PLEASE **CIRCLE** THE FOLLOWING IF YOU ARE CURRENTLY HAVING PROBLEMS WITH OR PREVIOUSLY HAD PROBLEMS WITH:

CONSTITUTIONAL WEIGHT LOSS FEVER EXCESSIVE FATIGUE NIGHT SWEATS

DESCRIBE _____

EYES ☐ YES ☐ NO INJURIES GLAUCOMA CATARACTS DATE OF LAST EXAM _____

DESCRIBE _____

EARS DATE OF LAST EXAM _____ WEARS HEARING AIDS
HEARING LOSS, EAR PAIN, EAR INFECTION RINGING IN EARS: LEFT _____ RIGHT _____ BOTH _____

NOSE, THROAT, MOUTH NASAL DRAINAGE MOUTH _____ COLOR _____
INABILITY TO SMELL SINUS PROBLEMS SORE THROAT MOUTH SORES
NOSEBLEEDS NASAL CONGESTION BALANCE DISTURBANCE (EX: VERTIGO, SPINNING)

DESCRIBE _____

PATIENT NAME: _____

REVIEW OF SYMPTOMS (Continued)

PLEASE **CIRCLE** THE FOLLOWING IF YOU ARE CURRENTLY HAVING PROBLEMS WITH OR PREVIOUSLY HAD PROBLEMS WITH:

CARDIOVASCULAR

CHEST PAIN OR ANGINA DATE OF LAST EKG: _____ HIGH BLOOD PRESSURE
IRREGULAR PULSE HEART MURMUR HIGH CHOLESTEROL LEG PAIN WHILE WALKING
SWELLING IN FEET OR HANDS
DESCRIBE _____

RESPIRATORY

ASTHMA BRONCHITIS EMPHYSEMA CHRONIC COUGH PNEUMONIA LUNG CANCER
SHORTNESS OF BREATH LUNG CANCER BLOODY SPUTUM LAST CHEST X-RAY _____
DESCRIBE _____

GASTROINTESTINAL

NAUSEA VOMITING INDIGESTION LIVER DISEASE JAUNDICE BLOOD IN YOUR VOMIT
ABDOMINAL PAIN COLON CANCER CHANGE IN YOUR BOWEL HABITS ULCERS OR GASTRITIS
DESCRIBE _____

Effective immediately, all patients are required to give 24 hours notice if you can not keep an appointment. If you do not give 24 hour notice, you will be charged a no show fee of \$40.00 that will need to be paid prior to any future appointments.

Effective immediately, **we do not accept fax requests from any pharmacy for refills.** If medication refills are needed, **you** must contact the office.

Effective immediately, we reserve the right to charge the patient for any forms that may need to be filled out.

Thank you,

Dr. Prafull K. Dave and Staff

PATIENT SIGNATURE: _____

DATE OF SIGNATURE: _____

EPWORTH SLEEP TEST

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____

CLINICAL DIAGNOSIS: _____ ICD 10 CODE: _____

DIRECTIONS: Please read each situation and answer how likely you would be to doze off or fall asleep, not just feel tired at these times.

This refers to the past three weeks of experience. Even if you have never experienced a situation just try and guess how it would have affected you. Use the scale beside each question to choose the most appropriate answer.

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>	<u>SITUATION</u>	<u>CHANCE OF DOZING</u>
1. Sitting and Reading	0. Never doze 1. Slight chance of dozing 2. Moderate chance of dozing 3. High chance of dozing	5. Lying down to rest in the afternoon	0. Never doze 1. Slight chance of dozing 2. Moderate chance of dozing 3. High chance of dozing
2. Watching Television	0. Never doze 1. Slight chance of dozing 2. Moderate chance of dozing 3. High chance of dozing	6. Sitting and talking with someone	0. Never doze 1. Slight chance of dozing 2. Moderate chance of dozing 3. High chance of dozing
3. Sitting quiet in public places (ex. public theater, meeting)	0. Never doze 1. Slight chance of dozing 2. Moderate chance of dozing 3. High chance of dozing	7. Sitting quietly after lunch without alcohol	0. Never doze 1. Slight chance of dozing 2. Moderate chance of dozing 3. High chance of dozing
4. Passenger in the car for an hour without break	0. Never doze 1. Slight chance of dozing 2. Moderate chance of dozing 3. High chance of dozing	8. In a car stopped for a few minutes in traffic	0. Never doze 1. Slight chance of dozing 2. Moderate chance of dozing 3. High chance of dozing

TOTAL SCORE: _____

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HIPAA DISCLOSURE FORM

PATIENT NAME _____ DATE _____

Preferred Correspondence Address _____

Preferred Contact Home Number _____ Cell Number _____

May we identify ourselves over the phone? YES NO May we leave a message? YES NO

I, the Patient, hereby authorize Prafull K. Dave, M.D., to release my medical information (appointments, lab results, radiological results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ PHONE: _____ Relationship: _____

Name: _____ PHONE: _____ Relationship: _____

Name: _____ PHONE: _____ Relationship: _____

Name: _____ PHONE: _____ Relationship: _____

Name: _____ PHONE: _____ Relationship: _____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: _____ Phone _____ Fax: _____

Doctor: _____ Phone _____ Fax: _____

Doctor: _____ Phone _____ Fax: _____

Doctor: _____ Phone _____ Fax: _____

Patient Signature _____ Date _____

Parent/Guardian Signature (if patient is a minor) _____ Date _____

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PATIENT CONSENT FOR PROVIDER APPEAL

Provider Information:

Name	PRAFULL K DAVE, M.D.	NPI	1326008582
Address	188 THOMAS JOHNSON DRIVE #200 FREDERICK, MD 21702	PHONE	301-695-6556
		FAX	301-263-7933

Date(s) of Service _____

Description of Services to be Appealed _____

Member Information and Consent

The member or the member's representative may not submit an appeal concerning the services/items listed in this consent form unless the member or the member's representative rescinds consent in writing. The member or the member's representative has the right to rescind consent at any time during the Appeal process. The member or the member's representative shall be automatically rescinded if the provider fails to file the Appeal or fails to continue to prosecute the Appeal through the second level review process. The member or the member's representative, if the member is a minor is legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The member or the member's representative understands the information in the member's consent form.

I agree to have the provider listed above to file an Appeal for me with my health insurance company if there is a question about coverage for the services listed above.

Patient Name _____ DOB _____ INS ID# _____

Address _____

Signature _____ Date _____

Consent from a Designated Representative

The patient listed above is unable to sign this consent form because of the(se) reason(s), and I consent for the patient.

Representative Name _____ Relationship to Patient _____

Representative Signature _____ Date _____

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TO ALL NEW PATIENTS AND ESTABLISHED PATIENTS

NEW OFFICE POLICY

EFFECTIVE APRIL 14, 2017

OUR OFFICE IS REQUIRING ALL PATIENTS TO KEEP A CREDIT CARD ON FILE WITH THE OFFICE. THIS DOCUMENT WILL BE CONSIDERED AS AUTHORIZATION TO BILL YOUR CREDIT CARD IN THE EVENT THAT THERE IS A BALANCE ON YOUR ACCOUNT AFTER INSURANCE HAS PROCESSED YOUR CLAIM.

WE WILL ATTEMPT TO NOTIFY YOU BEFORE CHARGING YOUR CREDIT CARD.

IF PATIENT IS A MINOR, A PARENT OR GUARDIAN WILL NEED TO SIGN.

PATIENT NAME (Please Print) _____

NAME OF PARENT / GUARDIAN (Please Print) _____

CIRCLE ONE: VISA MASTERCARD AMEX DISCOVER

NAME ON CARD (Please Print) _____

CREDIT CARD # _____

EXPIRATION DATE _____ **CVV CODE** _____

SIGNATURE OF CARD HOLDER _____

DATE OF SIGNATURE _____