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**	**PHONE**
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/FAX**
FAMILY PHYSICIAN	**ADDRESS**	**PHONE NUMBER/FAX**
DESCRIBE CURRENT PROBLEM(S) (REASON FOR TODAY'S VISIT)		
DATE OF ONSET		**FEMALES ONLY - POSSIBLE PREGNANCY?** ☐ YES ☐ NO

PLEASE INCLUDE PHYSICIAN FAX NUMBERS

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

HT _____WT_____BP_____TEMP_____

REASON FOR TODAY'S VISIT _____

PHARMACY NAME _____ STREET _____ CITY _____ STATE _____

EMAIL ADDRESS _____

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

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)

DECRIBE_____

REVIEW OF SYMPTOMS (Continued)

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_____

Member Information and Consent (IF APPEALS ARE NECESSARY FOR INSURANCE COMPANIES) Please Sign and Date

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 _____

***PRESCRIPTIONS**: **NARCOTIC PRESCRIPTIONS WILL NOT BE REPLACED IF LOST OR STOLEN.** PLEASE HAVE YOUR PHARMACY SEND REFILL REQUESTS.

***APPOINTMENTS**: A **$40.00 NO SHOW FEE** WILL BE APPLIED TO YOUR ACCOUNT IF 24 HOUR NOTICE IS NOT GIVEN FOR APPOINTMENT CANCELLATIONS. INSURANCE COMPANIES **DO NOT** REIMBURSE FOR NO SHOW FEES.

***FILLING OUT ADDITIONAL FORMS**: THERE WILL BE A **$30.00 FEE** FOR FILLING OUT FORMS

EPWORTH SLEEP TEST **ONLY COMPLETE IF YOU HAVE SLEEP ISSUES**

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.

SITUATION	CHANCE OF DOZING
1.Sitting and Reading	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
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
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
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
6.Sitting and talking with someone	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
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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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 _____