Pinky S. Tiwari, M.D.

Diplomate, American Board of Neurology

Diplomate, American Board of Electrodiagnostic Medicine

Scurlock Tower
6560 Fannin, Suite 1836
Houston, TX 77030

Telephone: (713) 790 – 1775 **Fax: (713) 790 – 1605**

Dear Sir or Madam:

At your first visit, you will be given a complete neurologic evaluation and your medical history will be reviewed. Any necessary diagnostic testing or further medical evaluation will then be discussed with you and orders provided.

The remaining pages comprise our new patient paperwork and we need you to print these forms and complete them prior to your visit. Please bring the following items with you to your first visit:

- The completed new patient forms.
- ALL insurance cards.
- Your driver's license or other picture identification.
- A list of your current medications (we will require this EACH visit).
- Any diagnostic reports, physician office notes, or hospital records regarding the current neurologic condition for which you are being seen.
- If you have an HMO or POS plan you will need to get a referral from your primary care physician. Without this referral - you will be required to pay in full for the visit. A current authorization is necessary for EACH visit and is the responsibility of the patient.
- Payment is expected at the time of service. Any co-pay, co-insurance or unmet deductible will be collected at the time of your visit. We accept all major credit cards.

Due to the congested traffic patterns in the medical center and limited parking, we suggest that you allow **PLENTY** of time to arrive in the office at least 30 minutes prior to your scheduled appointment time. This 30 minute pre-visit period is necessary to prepare your chart, review HIPAA protected healthcare information, and give Dr. Tiwari's assistant time to get you ready for your consultation with the doctor.

Since we must schedule patient appointments efficiently, and we wish to give each patient the care and attention that they deserve, it may be necessary to reschedule your appointment to another date if you arrive late.

Please give us at least 48-hours notice if you must cancel or reschedule your appointment; this allows us the opportunity to offer your appointment time to another patient.

Please call our office if you have any questions.

Sincerely,

Rosa Alvarez
Office Coordinator

PINKY S. TIWARI, M.D.

REGISTRATION INFORMATION

(PLEASE PRINT)

Date_____ Cellular or Home Phone_____

Patient _____
Last Name First Name Middle Initial

Street Address _____

City _____ State _____ Zip _____

Sex: M ☐ F ☐ Age_____Birthdate_____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Patient's School Name _____

Patient Employed By: _____

Business Address _____

Occupation _____ Business Phone _____

Spouse's (or responsible party) Name _____ Birthdate _____

Spouse Employed By: _____

Business Address _____

Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Patients Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? Yes ☐ No ☐ If yes:

Primary Insurance Company _____ Insured's Name _____

ID or Policy # _____ Group # _____ Contract # _____

Secondary Insurance Company (if any) _____ Insured's Name _____

ID or Policy # _____ Group # _____ Contract # _____

Are you covered under any of these programs? ☐ Medicare ☐ Medicaid ☐ CHAMPUS ☐ CHAMPVA

☐ Workers Compensation ☐ FECA Black

Is your condition related to employment (current or previous)? ☐ No ☐ Yes

Is your condition related to an auto accident? ☐ No ☐ Yes In which state? _____

Other Accident? ☐ No ☐ Yes Please describe: _____

_____

In case of an emergency, who should be notified?

Name _____ Relationship to patient: _____ Phone _____

Name _____ Relationship to patient: _____ Phone _____

Please list other doctors you have seen in the past 5 years:

Doctor: _____ City/State _____ Condition _____

Doctor: _____ City/State _____ Condition _____

Doctor: _____ City/State _____ Condition _____

How did you learn of our practice? _____

Who may we thank for referring you? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____

Name of Insurance Company

and assign directly to Dr. Pinky S. Tiwari all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made *either to me or* on my behalf to Dr. Pinky S. Tiwari for any services furnished *to* me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature *requests* that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier *agrees* to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

HISTORY OF PRESENT ILLNESS

I. INTRODUCTION

Patient Name _____ Today's Date _____

Age _____ Date of Birth _____ Race _____ Sex _____

With which hand do you write? Right ☐ Left ☐

Present Occupation _____ Past Occupation _____

If not presently working, please state the reason why: _____

_____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

II. HISTORY OF PATIENT'S PRESENT ILLNESS

Who referred you to Dr. Tiwari? _____

What is the reason for your consultation with the doctor? _____

_____

_____

How and when did this problem start? _____

_____

_____

Please check all the following that apply to you <u>with regard to this visit only</u>.

___ Problem with sense of smell
___ Problem with vision such as: blindness, blurred vision, or colored vision
___ Problem with double vision
___ Problem with facial numbness or with chewing
___ Problem with facial droopiness, salivation, tasting, loud noises, or tearing of the eyes
___ Problem with deafness, dizziness, vertigo, imbalance, or ringing in the ear
___ Problem with swallowing food (state if it is worse with solid foods or with liquids)
___ Problem with turning you head side to side
___ Problem with control of your tongue movements

Problem with other muscles

___ Strength (weakness, soreness, fatigue)
___ Abnormal movements (twitching, shaking, freezing up)
___ At rest (lying, sitting, standing)
___ While in motion (walking, running, climbing, swimming)
___ Control problem (Head, Arm, Leg, Trunk)
___ Imbalance while walking
___ Problem writing
___ Problem controlling urine or stool

Please check if you have, or have ever had, any of the following:

___Headache or facial pain
___Neck pain
___Spine pain (low back pain)
___Stroke
___Seizure
___Loss of consciousness (passing out, fainting)
___Memory loss or forgetfulness
___Learning disability
___Problem in sleeping
___Thinking problems (confusion, disorientation, feeling strange)
___Emotional problems (psychological, psychiatric)
___Problems at home, at work or school

Patient's Name _____ Today's Date _____

III. PATIENT'S MEDICATIONS

Are you allergic to any medications or drugs? ☐ Yes ☐ no

If you are allergic to any medications or drugs please list them, with the type of reaction:

Medication	Reaction
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

List any medication you are taking at this time:

Medication	Strength Per Pill (mg)	Number of Pills taken at one time	How many times per day
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____
7) _____	_____	_____	_____
8) _____	_____	_____	_____
9) _____	_____	_____	_____

IV. PATIENT'S PAST MEDICAL HISTORY

Please check if you have ever had any problems with the following systems:

___Heart ___Kidneys
___Lung ___Glands
___Skin ___Digestive
___Blood ___Bone or Muscle

Women – When was your last menstrual period? _____

Men – Do you have problems with erection? _____

Please check if you have ever had any of the following:

____Cervical or Lumbar Disk Herniation
____Spine or Head Injury
____Stroke or TIA
____Heart Attack or Angina
____High Blood Pressure
____Cancer, Leukemia, or Lymphoma
____Epilepsy or Seizure
____Meningitis, Encephalitis or Brain Abscess
____ALS, Ataxia, Muscular Distrophy, Polymyositis
____Diabetes, Anemia, or B-12 Deficiency
____Bell's Palsy or Shingles
____Syringomyelia
____Hydrocephalus
____Tuberculosis
____Stomach Ulcer
____Rheumatic Fever
____Headaches such as Tension, Migraine or Cluster

Other _____

V. SURGICAL HISTORY

Please list any previous operations you have had:

PREVIOUS OPERATIONS

	Type of Operation	Year	Surgeon/Location
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____

Any previous spine or head injuries? ☐ Yes ☐ No

If yes: When _____ How many times? _____

How did it happen? _____

_____

How long did it take to recover? _____

_____

_____

Treatment? _____

_____

_____

VI. PATIENT'S FAMILY HISTORY

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of Brothers? _____ Number Living? _____ Number Deceased? _____

Number of Sisters? _____ Number Living? _____ Number Deceased? _____

Number of Children? _____ Number Living? _____ Number Deceased? _____

Serious Illness of Children _____

Do you know of any blood relative that has had any of the following (Please circle and give relationship):

Cancer _____ Heart Disease _____ Rheumatic Fever _____ Tuberculosis _____

Leukemia _____ High Blood Pressure _____ Stroke _____ Diabetes _____

Epilepsy _____ Bleeding Tendency _____ Asthma _____ Multiple Sclerosis _____

ALS _____ Alcoholism _____ Depression _____ Alzheimer's Disease _____

Parkinson's Disease _____ Other_____

VII. **PATIENTS'S SOCIAL HISTORY**

HABITS

	Quantity	How Often	Have You Quit	When Did You Quit
Alcohol				
Tobacco				
Caffeine				
Drugs				

VIII. **PLEASE LIST ALL THE TESTS YOU HAVE HAD IN THE PAST *RELEVANT TO THE PROBLEM FOR WHICH YOU ARE SEEING US***

_____

_____

_____

_____

_____

_____

IX. **PLEASE LIST ANYTHING SPECIFIC YOU WOULD LIKE TO DISCUSS WITH DR. TIWARI**

_____

_____

_____

_____

_____

_____

_____

_____

Contact me by mail at the following address: _____

_____

Email: _____

Contact me at the following telephone numbers: ☐ Daytime: _____
*Preferred contact telephone – please check box

☐ Evening/Weekends: _____

☐ Cell: _____

AUTHORIZATION TO DISCUSS PRIVATE HEALTH INFORMATION WITH THE FOLLOWING FAMILY MEMBER OR OTHER DESIGNATED PERSON

Pinky S. Tiwari, M.D. may discuss my health information, if necessary, with the following persons without my written permission at each occurrence.

_____	_____	_____
NAME	RELATIONSHIP	PHONE
_____	_____	_____
NAME	RELATIONSHIP	PHONE

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Pinky S. Tiwari, M.D. may obtain/furnish from/to any consulting physician or insurance company, and its representative any information or copies of all hospital, medical records, consultations, and prescriptions relating to illness or injury. A copy of this authorization shall be effective and valid.

INITIAL: _____

AUTHORIZATION TO LEAVE MESSAGES

Pinky S. Tiwari, M.D. may leave necessary messages at my home, place of employment, or cell phone recorder or voice mail or with a person answering the phone numbers indicated above.

INITIAL: _____

AUTHORIZATION FOR BILLING

Pinky S. Tiwari, M.D. may obtain direct payment from insurance benefits otherwise payable to me for services received. A copy of this authorization shall be effective and valid. I understand that I am responsible for any remaining balance that my insurance does not pay. I acknowledge that my office visit co-pay, any co-insurance or unpaid deductible will be due at the time of service.

INITIAL: _____

GENERAL CONSENT FOR TREATMENT

I voluntarily present myself to Pinky S. Tiwari, M.D. for examination and evaluation. I consent to any necessary procedures, medical care, and other services under the general and specific instructions of Pinky S. Tiwari, M.D. I have the right to accept or decline any healthcare service requested by Pinky S. Tiwari, M.D. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination.

INITIAL: _____

I have read, understand and had the opportunity to ask questions regarding the Health Information Privacy Practices of Pinky S. Tiwari, M.D.

PATIENT SIGNATURE _____ DATE _____

PLEASE PRINT YOUR NAME: _____