Neurology Clinic of Maryland, Inc.
Sheetal Harish Wagle, MD
10770 Hickory Ridge Road
Columbia, MD 21044
Phone: (410)988-4013 Fax:(410) 497-1110

Patient Registration Form

Patient Information:

Last name: _____First: _____ Middle: _____
Date of Birth: _____Marital Status: _____
SSN:_____Gender: (Circle One: Male / Female / Non-Binary)
Home Address: _____
_____
Mobile Phone: _____
Work Phone: _____Home Phone: _____
Preferred Method of Contact: (Circle One: Mobile / Work / Home)
Email address: _____
Would you like to receive reminders on your email address? YES / NO

Emergency Contact:

Name:_____Phone Number:_____
Relationship to Patient:_____

Employment Information:

Employer Name: _____
Employer Address: _____
Phone Number: _____

Medical Contacts:

Primary Care Provider: _____ Phone: _____
Referring Physician: _____ Phone: _____
Preferred Pharmacy: _____
Pharmacy Location/Address: _____

Reason for Visit:

_____

Are you here for Worker's Compensation /Injury? (Circle One: YES / NO)
Are you here for injury from a car / vehicle accident? (Circle One: YES / NO)
Are there lawyers involved? (Please list for **PRESENT** and **FUTURE** cases): (Circle One: **YES / NO**)

Law Firm Office Name: _____
Phone Number: _____Fax Number: _____
Claim or Case Number: _____

Insurance information:

Primary Insurance Company:_____
Member ID:_____
Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____
Member ID: _____
Policy Number: _____ Group Number: _____

If policy holder is different from patient:
Name of Policy holder:_____ Relationship to Patient_____
Date of Birth:_____ Phone:_____
Address:_____
_____

INSURANCE AUTHORIZATION AND ASSIGNMENT ACKNOWLEDGEMENT

The above information is accurate to the best of my knowledge. I request the direct payment of authorized medical benefits for any services provided by Sheetal Wagle, M.D. Neurology Clinic of Maryland Inc. I authorize any holder of medical information regarding me to release this information to my insurance carrier (or intermediaries) to the Health Care Financing Administration and its agents, to my attorney, or other physician's office. I authorize my insurance company to release any information required to process my claims. Additionally, I permit a copy of this authorization to be used in place of the original. This agreement will remain in effect until I revoke, in writing, this authorization. I understand that because these services performed for me or my legal dependent, I am financially responsible for all charges, whether paid by the insurance carrier. I acknowledge that if my account is sent to a collection agency, I am responsible for all costs of collections, including collection fees and attorney's fees. I am also responsible for obtaining any necessary referrals/medical records needed for services rendered. If there is not a valid referral on file, I am responsible for the charges incurred.

Signature: _____Date: _____

Print Name: _____

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Please read and sign: We understand if patients must reschedule appointments. If needed, please contact the clinic at least 24 hours in advance at (410) 988-4013.

If the patient **fails** to contact the clinic **24 hours in advance** before the missed appointment or does not show up, there will be a no show charge of **$50.00.**

If the patient has missed three or more consecutive appointments, the office has the right to patient dismissal.

I hereby acknowledge that I have read and fully understand the office policies.

Signature: _____ Date:_____

FMLA/Disability/All Patient Forms:

1. Blank forms will not be accepted. Personal information must be completed.
2. Forms are completed for those accounts in good standing. Outstanding balances need to be paid before forms being filled out.
3. There is a **$40.00 fee** due when forms are completed.
4. These forms cannot be faxed or mailed to you or your employer. They must be picked up directly from the office.

We cannot complete forms within the same day. Please allow us 10-15 business days to return all forms to you.

All prescription refills should be requested during regular office hours when your medical record is available to the doctor. If you would like your prescription telephoned to your pharmacy, please have the phone number available when you call.

Please call for refills a few days before your prescription runs out, rather than waiting until last minute. Routine prescription refills will generally be telephoned within 48 hours.

Signature: _____ Date: _____

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New Patient Consent to Use and Disclosure of Health Information for treatment, payment or Healthcare Operations:

I _____understand that as part of my health care, Neurology Clinic of Maryland, Inc) originates and maintains paper and electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this is information serves as the basis for planning my care and treatment:

- A means of communication among the many health professions which contribute to my bill
- A source of information tor applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were provided, and a tool for routine healthcare operations such as assessing the quality and reviewing the competence of healthcare professionals

I_____understand and have been provided with a Notice of Privacy Practices that provided a complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice before signing this consent
- The right to object to using my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I_____understand that Neurology Clinic of Maryland, Inc is not required to agree to the restrictions requested, understand that I may revoke this consent in writing, except to the extent that the organization has already acted in the reliance thereon, I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by section 164.506 of the Code of Federal Regulation.

I_____understand that Neurology Clinic of Maryland, Inc reserves the right to change their notice and practices and prior to implementation, under Section 164.520 of the Code of Federal Regulation. Should Neurology Clinic of Maryland, Inc change their notice, they will send a copy of the notice to the address I have provided (whether U.S, mail or if I agree, email)

I_____understand that as part of this organizations, treatment payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax, fully understand and (Circle one: ACCEPT / DECLINE) the terms of this consent.

Signature: _____Date: _____

Please complete this form to ensure that we have the most up-to-date **PAST & PRESENT** medical history.

Patient Name:_____Date of Birth:_____

Social History:

Tobacco / Tobacco Products: Nonsmoker [ ] Former Smoker [ ] Current Smoker [ ] If yes, how and and how often?_____

Alcohol: Yes [ ] No [ ] If yes, how many and how often? _____

Diet: Normal [ ] Vegetarian [ ] Vegan [ ] Other [ ]
(Please Specify): _____

Illegal Substance Use: Yes [ ] No [ ] If yes, please specify_____

(All information is confidential)

Drug Allergies:

_____

_____

Family Medical History:

	Father	Mother	Siblings	Others (Specify)
Hypertension				
High Cholesterol				
Heart Disease				
Heart Attack				
Diabetes Type I/II				
Stroke				
Muscle Disorder				
Multiple Sclerosis				
Parkinson's Disease				
Aneurysm				
Seizures				
Headache/Migraine				
Mental Illness				
Cancer (Specify)				
Alzhemier's				
Dementia				
Other (Specify)				

_____

_____

Patient Name:_____Date of Birth: _____

Past Medical History:

[ ] Diabetes	**[ ]** Bleeding Disorder	**[ ]** Back Pain / Injury	**[ ]** High Blood Pressure
[ ] Heart Disease	**[ ]** Headaches/Migraines	**[ ]** Gastric Reflux	**[ ]** Kidney Disease
[ ] Lung Disease	**[ ]** Liver Disease	**[ ]** Parkinson's	**[ ]** Lupus
[ ] Alzheimer's	**[ ]** Rheumatoid Arthritis	**[ ]** Stroke	**[ ]** Seizures
[ ] Dementia	**[ ]** Neuropathy	**[ ]** Aneurysm	**[ ]** Thyroid Disease
[ ] Anxiety	**[ ]** Depression	**[ ]** Cancer (Specify)	**[ ]** Other (Specify)

Specify: _____
_____

Please check if there is no prior medical history: [ ]

Prior Surgical History: (Please list the name and date of each surgery)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please check if there are no surgery history: [ ]

Diagnostic Testing: (Please check box)

	CT	MRI	X-Ray	PET Scan	DAT Scan	EEG	EMG
Date							
Location							

Patient Name: _____ Date of Birth: _____

Current Medications:

Medication Name	Dosage	Instructions