**Deepak Tikku, M.D.**
**Neurology Center of Florida**
**2808 Enterprise Road Suite 104, Debary, FL 32713 Tel: (386) 624-6900 Fax:: (386) 624-6993**

# NEW PATIENT INFORMATION RECORD

(Please print legibly and please answer ALL questions)

*Welcome to Neurology Center of Florida*

Date:_____ Circle one: Single Married Widowed Divorced

***Personal***

Patient Legal Name: (FIRST)_____(LAST)_____ Date of Birth:_____ Gender: Male/Female

Social Security # (***required***):_____ **Email Address** :_____

Home phone:_____ Cell phone:_____ Work phone:_____

Permanent Address:_____City_____State_____Zip_____

*Temporary Address*:_____City_____State_____Zip_____

Employer: _____Race:_____ Language:_____ Hispanic or Non-Hispanic (circle one)

Is this visit related to an auto accident? YES/NO Is this visit related to work comp? YES/NO

Emergency Contact:_____Phone:_____Relationship:_____

**Confidential Communication: Please advise on how you wish to be contacted by our office**

□ Home □ Work □ Cell □ Mail □ Email □ Leave a detailed message □ Leave message w/ call-back number ONLY

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***ALL PATIENTS please complete below***

**INSURANCE INFORMATION** (Please provide the receptionist with your insurance card(s) and photo ID)

Primary Insurance Name:_____ID#:_____

Policyholder's Name:_____Policyholder's D.O.B.:_____

Secondary Insurance Name:_____ID#:_____

Tertiary Insurance Name:_____ID#:_____

Referring/PCP Physician's Name:_____Ref Physician's Phone:_____

Patient's Pharmacy:_____Pharmacy Phone:_____

Please list the person(s) (*other than yourself*) you request to have your **CONFIDENTIAL INFORMATION** RELEASED TO (*optional*):

Name:_____Relationship:_____Phone:_____

*Thank you for choosing Neurology Center of Florida,*
*we are glad you are here and look forward to a long lasting relationship*

*Neurology Center of Florida*

**Patient Financial Policy Agreement**

We are committed to providing you with quality healthcare and would appreciate your commitment to adhere to this Financial Policy Agreement. Please read this policy carefully and sign the Acknowledgment section at the bottom of this form. Please do not hesitate to ask a member of our staff if you have any questions.

**For Medicare Recipients ONLY**

Name of Patient:_____Date:_____

I request payment of authorized Medicare benefits be made directly to Dr. Deepak Tikku at Neurology Center of Florida for any services provided to me. I authorize the release of information to Medicare and my secondary insurance to assist in the processing and payment of all claims. Dr. Deepak Tikku agrees to accept Medicare assignment and I will be responsible for any deductible, coinsurance or any non-covered services determined by Medicare.

## FOR ALL PATIENTS– Please read and sign

1. All patients are required to provide a valid, current proof of insurance and a copy of your driver's license. Failure to do so might result in a denial of payment from your insurance plan and the balance will be your responsibility.

**Payment of all deductibles, co-pays, coinsurances and other patient financial responsibilities are required at each office visit *unless payment arrangements have been made in advance*.**

***Your health policy is a contract between you and your insurance company and we are NOT a party to that contract.**

2. We will submit your claim and assist you in any way reasonable to help get your claim paid. It is your responsibility to provide your insurance company with any requested information in a timely manner. ****You are responsible for any non-covered services by your plan***.
3. If we do not participate with your insurance plan, we will submit a claim to your insurance plan as a courtesy to you; however, payment is required at the time services are rendered.
4. **SELF PAYMENT**: Payment is expected at the time services are rendered unless prior arrangements have been made.
5. **MEDICAID**: *(if applicable)* It is the patient's responsibility that all proper authorizations have been obtained from your medipass provider; otherwise, payment is expected at the time services are rendered.
6. **APPOINTMENTS**: Excessive no-shows or rescheduling of appointments may result in the discharge from the practice.

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**By signing below, you acknowledge that you have read, understand and agree to the above Patient Financial Policy Agreement.**

I authorize my insurance benefits to be paid directly to Dr. Deepak Tikku and I authorize the release of my medical information to my insurance company when required to facilitate payment of a claim.

_____ _____

Patient Signature/Legal Guardian Date

_____

Printed Name

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

**(***See attached copy - A copy can be obtained from the receptionist***)**

I,_____, have received a copy of this office's Notice of Privacy Practices.

(Please PRINT name)

{Signature}_____{Date}_____

**For Office Use Only**

*We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:*

□ Individual refused to sign □ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement □ Other (Please Specify)

_____

_____

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Name:_____Date:_____D.O.B.:_____

**Please list any medication allergies you may have (*if no allergies, please write "None"):***

1._____

**Reason for Today's Appointment**: _____Height: _____ Weight:_____

**Please list ALL medications you are presently taking with dosage and frequency:**

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9 ._____

5._____ 10._____

**Medical History**

Do you have or have **you** EVER had any of the following: *Please circle all that apply.*

| | | | |
|---|---|---|---|
| Arthritis | Depression | Loss of Balance/Falls | Stroke (CVA) |
| Asthma | Diabetes Type?_____ | Lung Disease | Thyroid Problems |
| Bowel/Bladder Problems | Fainting/Dizziness | Other Heart Conditions | TIA (Transient Ischemic Attacks) |
| Cancer: (TYPE) _____ | Fibromyalgia | Pacemaker/Defibrillator | Weight Loss |
| Congestive Heart Disease | Headaches/Migraines | Prostate Problems | |
| Coronary Artery Disease/Angina | High Blood Pressure | Seizures | |

**Tobacco History**: □ Never Smoked □ Former-Smoker □ Occasional □ Smoker _____# cigarettes per day

**Alcohol History:** □ Non-drinker □ Occasional Drinker □ Alcohol daily □ History of Alcohol Consumption

**Family History**: Mother: Alive/Deceased : Medical Conditions:_____

Father: Alive/Deceased : Medical Conditions:_____

Brother(s): Alive/Deceased : Medical Conditions:_____

Sister(s): Alive/Deceased : Medical Conditions:_____

Children: Alive/Deceased : Medical Conditions:_____

**Other Medical Illnesses NOT Listed:**

_____

Previous SURGERIES within the past 5 years:

_____