Diagnostic Neurology
Clinic of Houston

ATTENTION PATIENTS

Our office is transitioning to Electronic Medical Records. We will be sending test results and patient care documents through a patient portal.

To facilitate portal set up, we ask that you supply us with an active email address. You will receive an email with instructions for how to access the portal.

Thank you,

Diagnostic Neurology Clinic of Houston

Please print:

Patient Name: ____

Email Address: ____

Diagnostic Neurology
Clinic of Houston

FRONT OFFICE: 713.467.8491

PATIENT INFORMATION

Date: ____________________ Patient Name: ____

____ Male ____ Female Birth Date: _________________________ Home Phone: __________________________

Cell Phone: __________________________ EMail: ____

Address: ____ City: ___________________ State: ____ Zip: _________

___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated SS#: __________________________

Who may we thank for referring you? If by a physician, please write "MD" or "Dr.": ____________________________

Emergency Contact Name: ___________________________________ Emergency Contact Phone #: _______________

Relation to Patient: ____

Race (please select): Preferred Language: ____________________________

___ White ___ Hispanic ___ American Indian or Alaskan Native ___ Black or African American

___ Chinese ___ Filipino ___ Japanese ___ Korean ___ Native Hawaiian ___ Pacific Islander

___ Vietnamese ___ Other ___ DECLINE TO ANSWER

PRIMARY MEDICAL INSURANCE

Name of Insured: ____ Relation to Patient: ____________________

Birth date of Insured: ______________________________ SS# of Insured: _____________________________________

Name of Employer: _______________________________ Work Phone: _______________________________________

Insurance Company: _____________________________ ID#: ___________________________ Group#: _____________

Ins Company Address: __________________________________ City: ___________________ State: ____ Zip: ________

SECONDARY MEDICAL INSURANCE

Name of Insured: ____ Relation to Patient: ____________________

Birth date of Insured: ______________________________ SS# of Insured: _____________________________________

Name of Employer: _______________________________ Work Phone: _______________________________________

Insurance Company: _____________________________ ID#: ___________________________ Group#: _____________

Ins Company Address: __________________________________ City: ___________________ State: ____ Zip: ________

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY HEALTH CARE, ADVICE AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTRATING CLAIMS FOR INSURANCE BENEFITS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR.

____ ______________________________

Signature of Patient or Parent/Guardian Date

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Patient Name: ____________________ Date: ____________

MEDICAL INFORMATION

Chief Complaint (main reason for being here today): ____________________

____

Do you have any of the following symptoms? (CHECK ALL THAT APPLY)

___ HEADACHE
___ FACIAL PAIN
___ DIZZINESS
___ LOSS OF BALANCE
___ WEAKNESS
___ NUMBNESS
___ TINGLING
___ VISION LOSS OR SPOTS
___ DOUBLE VISION
___ SLURRED SPEECH
___ SWALLOWING PROBLEMS
___ DROOLING OR CHOKING
___ HOARSENESS
___ LOSS OF SMELL OR TASTE
___ HEARING LOSS
___ MEMORY LOSS
___ CONFUSION
___ SLEEP DISTURBANCE
___ PASSING OUT
___ TREMOR
___ STIFFNESS
___ PROBLEMS WALKING
___ NECK PAIN
___ BACK PAIN
___ ARM PAIN
___ LEG PAIN
___ MUSCLE CRAMPS
___ MUSCLE TWITCHING
___ RESTLESS LEGS
___ ABNORMAL MOVEMENTS
___ FEVER OR CHILLS
___ CHEST PAIN
___ SHORTNESS OF BREATH
___ STOMACH / BOWEL PAIN
___ NAUSEA OR VOMITING
___ INDIGESTION
___ DIARRHEA
___ CONSTIPATION
___ IMPOTENCE
___ LOSS OF BLADDER CONTROL
___ FREQUENT URINATION
___ RASH

Have you had or been diagnosed with any of the following? (CHECK ALL THAT APPLY)

___ STROKE
___ TRANSIENT ISCHEMIC ATTACK (TIA)
___ PARKINSON'S DISEASE
___ ALZHEIMER'S DISEASE
___ SEIZURES / EPILEPSY
___ MIGRAINE
___ TENSION HEADACHE
___ SINUS HEADACHE
___ NEURALGIA
___ NEUROPATHY
___ MUSCLE DISEASE
___ HEAD INJURY
___ BRAIN SURGERY
___ BRAIN TUMOR
___ OTHER CANCER
(DESCRIBE: ____________)
___ MULTIPLE SCLEROSIS
___ MYASTHENIA GRAVIS
___ NECK SURGERY
___ BACK SURGERY
___ OTHER SURGERY
(DESCRIBE: ____________)
___ HIGH BLOOD PRESSURE
___ DIABETES
___ ARTHRITIS
___ HEART ATTACK / ANGINA
___ IRREGULAR HEARTBEAT
___ HEART SURGERY
___ CAROTID ARTERY SURGERY
___ KIDNEY DISEASE
___ LIVER DISEASE
___ EMPHYSEMA
___ ASTHMA OR BRONCHITIS

ALLERGIES: ____________________

Headache Patients:

How frequent are your headaches? ___ Rare ___ 1 or 2 per month ___ 1 or 2 per week ___ Daily
What do you take for your headaches? ____________________
Can you identify anything that triggers your headaches? ____________________
Are your headaches: ___ Always one side ___ Always both sides ___ Either left or right-sided
How many work or school days per month have you missed due to headaches? ____________

Female Patients:

When was your last period? ____________ Are your periods regular? ___ Yes ___ No
If no periods: ___ Starting menopause ___ After menopause ___ Hysterectomy ___ Other: ____________
Are you pregnant? ___ Yes ___ No Are you trying to become pregnant? ___ Yes ___ No
Do you take birth control pills or other hormones? ___ Yes ___ No If yes, which one? ____________

NOTE: The above information is part of the Review of Systems and Past Medical History, and inclusion of this data in the medical record indicates that detailed physician review of the information provided has been performed.

Diagnostic Neurology
Clinic of Houston

Joanne Y. Kim, MD

FRONT OFFICE: 713.467.8491

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner (check all that apply):

_______ Home Telephone: ____

Okay to leave a message with detailed information? ___YES ___ NO

_______ Cell Phone: ____

Okay to leave a message with detailed information? ___YES ___ NO

_______ Work Phone: ____

Okay to leave a message with detailed information? ___YES ___ NO

Written Communication:

Okay to mail to home address? ___ YES ___ NO

Okay to mail to work address? ___ YES ___ NO

Okay to fax? ___ YES ___ NO SECURE FAX NUMBER: ______________________

PERSONS TO WHOM INFORMATION MAY BE DISCLOSED

In the space below, please list names, phone numbers and relationship of any family members or individuals you give us permission to speak with regarding your medical treatment and billing inquiries:

Name: ______________________________ Relation: ____________________ Telephone: ______________

Name: ______________________________ Relation: ____________________ Telephone: ______________

Name: ______________________________ Relation: ____________________ Telephone: ______________

Name: ______________________________ Relation: ____________________ Telephone: ______________

Name: ______________________________ Relation: ____________________ Telephone: ______________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I am able to receive and read a copy of the Notice of Privacy Practice from Diagnostic Neurology Clinic of Houston. I have also been given the opportunity to ask questions about this notice. My signature below confirms that this has been provided to me and I can request a copy.

____ ____________________________

Signature of Patient or Parent/Guardian Date

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PATIENT MEDICATION INFORMATION

Date: ____________________ Patient Name: ____

Birth Date: _____________________________

Pharmacy Name: ____ Pharmacy Phone: ___________________________

ALLERGIES:

____

____

CURRENT Medications (Prescribed and Over-the-counter) and Supplements with Dosage:

1. ____ Dose: __________________
2. ____ Dose: __________________
3. ____ Dose: __________________
4. ____ Dose: __________________
5. ____ Dose: __________________
6. ____ Dose: __________________
7. ____ Dose: __________________
8. ____ Dose: __________________
9. ____ Dose: __________________
10. ____ Dose: __________________
11. ____ Dose: __________________
12. ____ Dose: __________________
13. ____ Dose: __________________
14. ____ Dose: __________________
15. ____ Dose: __________________

Discontinued Medications:

1. ________________________________ Date Discontinued: __________ Reason: __________________________
2. ________________________________ Date Discontinued: __________ Reason: __________________________
3. ________________________________ Date Discontinued: __________ Reason: __________________________
4. ________________________________ Date Discontinued: __________ Reason: __________________________

Diagnostic Neurology
Clinic of Houston

Effective August 1, 2021

Same-Day Cancellation Policy and No-Show Policy

Diagnostic Neurology is committed to scheduling each patient with enough time to allow for the attention necessary to give the best care possible.

Because we do not overbook, no-shows and same-day cancellations can pose a significant hardship on our practice.

Additionally, appointment slots that are booked and then result in no-shows or same-day cancellations contribute to the length of time it takes for all patients to obtain an appointment.

Therefore, effective August 1, 2021, Diagnostic Neurology will charge a fee of $100 for all no-shows and same-day cancellations.

Patients are asked to arrive 10 minutes prior to all scheduled appointments. All patients arriving more than 5 minutes past the schedule appointment time will be required to reschedule the appointment for another day.

Thank you,

Diagnostic Neurology Clinic of Houston

Please print:

Patient Name: ______________________________

Patient Signature: ______________________________

Witnessed by: ______________________________