CHESTER NEUROLOGY, PLLC
14 RYE RIDGE PLAZA, SUITE# 225
RYE BROOK, NY 10573

CHESTER NEUROLOGY, PLLC
984 NORTH BROADWAY SUITE# 305
YONKERS, NY 10701

TEL: 914-816-1941
FAX: 914-885-1794
Web: www.chesterneurology.com
Email: md@chesterneurology.com

PATIENT INFORMATION

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____
MIDDLE NAME: _____ DATE OF BIRTH: _____/_____/_____
SS#: _____
ADDRESS: _____
SEX: ·MALE ·FEMALE

TEL: (CHECK THE PREFERRED) _____ HOME ( )
_____ WORK ( )
_____ CELL ( )

EMAIL ADDRESS: _____
EMERGENCY CONTACT NAME: _____
EMERGENCY CONTACT PHONE: _____

EMPLOYMENT INFORMATION

EMPLOYER'S NAME: _____
ADDRESS: _____
PHONE NUMBER: _____

PRIMARY PHYSICIAN'S INFORMATION

NAME: _____
ADDRESS: _____
PHONE: _____
FAX: _____
REFERRING SOURCE IF OTHER THAN PRIMARY PHYSICIAN: _____

PHARMACY INFORMATION

PHARMACY NAME: _____
PHARMACY ADDRESS: _____
TELEPHONE # _____

Name: _____ DOB: _____

MEDICAL INTAKE

CHIEF COMPLAINT: _____

PAST MEDICAL AND SURGICAL HISTORY:

☐DIABETES ☐HYPERTENSION ☐HIGH CHOLESTEROL ☐HEART DISEASE ☐STROKE/TIA

☐EPILEPSY ☐BRAIN INJURY ☐MIGRAINES ☐NECK PAIN ☐LOW BACK PAIN ☐REFLUX

☐ASTHMA ☐COPD ☐DEPRESSION ☐ANXIETY ☐BLOOD CLOTS ☐SLEEPING DISORDERS

OTHER: _____

SURGERIES AND DATES: _____

HOSPITALIZATION HISTORY: _____

SOCIAL HISTORY:

OCCUPATION: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED

CHILDREN: ☐ YES ☐ NO

SMOKING: ☐NEVER ☐QUIT (SPECIFY HOW LONG AGO) ☐CURRENT

ALCOHOL: ☐NEVER ☐SOCIAL ☐ON OCCASIONS ☐FREQUENT

ALLERGIES: _____

MEDICATIONS WITH DOSAGES AND FREQUENCY:

Name	Dosage	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

Name: _____ DOB:_____

FAMILY HISTORY (please check off the condition that is applicable in the family and the relationship).

- ☐ HEART DISEASE _____
- ☐ HYPERTENSION_____
- ☐ DIABETES_____
- ☐ HIGH CHOLESTEROL _____
- ☐ STROKE_____
- ☐ CANCER (PLEASE SPECIFY)_____
- ☐ EPILEPSY/SEIZURES_____
- ☐ ALZEIHMER'S DEMENTIA _____
- ☐ MIGRAINES_____
- ☐ DRUG OR ALCOHOL ADDICTION_____
- ☐ DEPRESSION/PSYCHOSIS_____
- ☐ MULTIPLE SCLEROSIS_____
- ☐ LUPUS _____
- ☐ RHEUMATOID ARTHRITIS_____
- ☐ OSTEOARTHRITIS_____
- ☐ BLOOD CLOTS _____
- ☐ PARKINSON'S DISEASE _____
- ☐ ESSENTIAL TREMORS_____
- ☐ NEUROPATHY_____
- ☐ MUSCLE DISEASE_____
- ☐ OTHER _____

REVIEW OF SYSTEMS

Constitutional: ☐No Problems ☐Fever ☐Chills ☐Night Sweats ☐Dizziness
Other:_____

Cardiovascular: ☐No Problems ☐Chest Pain ☐Swelling of Extremities ☐Hypertension
Other:_____

Endocrine: ☐No Problems ☐Thyroid Problem ☐Diabetes
Other:_____

Eyes: ☐No Problems ☐Blurry Vision ☐Double Vision ☐Itchiness ☐Blindness ☐Photophobia
Other:_____

Gastrointestinal: ☐No Problems ☐Nausea ☐Vomiting ☐Bleeding ☐Liver Problem ☐Diarrhea
Other:_____

Respiratory: ☐No Problems ☐Asthma ☐Pneumonia ☐Cough ☐Sputum ☐Wheezing
Other:_____

Genitourinary: ☐No Problems ☐Bleeding ☐Burning ☐Kidney Stones ☐Prostate Problem
Other:_____

Hematologic: ☐No Problems ☐Easy Bruising ☐Anemia ☐Clotting Problem
Other:_____

Immunologic: ☐No Problems ☐HIV Positive ☐AIDS
Other:_____

Name: _____ DOB:_____

Lymphatic: ☐No Problems ☐Nodes ☐Lumps
Other:_____

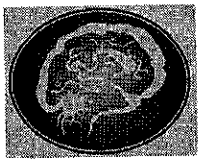
Musculoskeletal: ☐No Problems ☐Pain ☐Swelling ☐Weakness ☐Stiffness Arthritis
Other:_____

Neurological: ☐No Problems ☐Numbness ☐Memory Problems ☐Vertigo
Other:_____

Ob/Gyn (females only): ☐No Problems ☐Pregnant ☐Irregular Periods ☐Discharge
Other:_____

Psychiatric: ☐No Problems ☐Depression ☐Anxiety ☐Hallucinations ☐Suicidal Tendency ☐Drug
AddictionOther:_____

Skin: ☐No Problems ☐Rash ☐Lesion ☐Pain
Other:_____



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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members of Chester Neurology, PLLC or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities at Chester Neurology, PLLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Also we may remove any information that identifies you from your medical record for the purpose of research/study and this can be done without knowing who you are.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific

written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

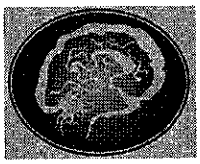
- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.



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Acknowledgement of Notice of Privacy Practices

I _____ acknowledge that I have received a copy of the "Notice of Privacy Practices" per HIPPA. This notice describes how Dr. Roshni Karnani and staff of Chester Neurology PLLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____
(signature of patient)

_____
(date)