CHESTER NEUROLOGY, PLLC
10 RYE RIDGE PLAZA, SUITE# 105
RYE BROOK, NY 10573

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

TEL: 914-816-1941
FAX: 914-921-1840
Web: www.chesterneurology.com
Email: md@chesterneurology.com

PATIENT INFORMATION

TODAY'S DATE: _____

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

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

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

EMPLOYMENT INFORMATION

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

ARE YOU HERE FOR A WORK-RELATED INJURY? ( ) YES ( ) NO
ARE YOU HERE FOR A NO FAULT CLAIM? (CAR ACCIDENT) ( ) YES ( ) NO
ARE YOU HERE FOR A MEDICAL MARIJUANA CONSULTATION ( ) YES ( ) NO
(IF YES TO ANY OF THE ABOVE, PLEASE SPEAK TO THE FRONT DESK STAFF BEFORE PROCEEDING TO THE NEXT PAGE)

PRIMARY PHYSICIAN'S INFORMATION

NAME: _____
ADDRESS: _____
PHONE: _____
FAX: _____

REFERRING PHYSICIAN'S NAME: _____

PHARMACY INFORMATION

PHARMACY NAME: _____
PHARMACY ADDRESS: _____
TELEPHONE # _____

Name: _____ DOB: _____
Height:_____ Weight:_____

MEDICAL INTAKE

CHIEF COMPLAINT: _____

PAST MEDICAL AND SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLIES)

HYPERTENSION	NARCOLESPY	DIABETES	EPILEPSY	MIGRAINES	NECK PAIN
HYPOTHYROIDISM	REFLUX	COPD	ANXIETY	DEPRESSION	ASTHMA
ATRIAL FIBRILLATION	HIGH CHOLESTEROL	LOW BACK PAIN	OBSTRUCTIVE SLEEP APNEA	BRAIN INJURY	HEART DISEASE
STROKE/TIA					

ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE?
_____

SURGERIES AND DATES: _____

SOCIAL HISTORY:

OCCUPATION: _____

MARITAL STATUS	SINGLE	MARRIED	DIVORCED	SEPARATED
SMOKING	NEVER	QUIT(How Long?)	CURRENT	
ALCOHOL	NEVER	SOCIAL	ON OCCASIONS	FREQUENT

ANY OTHER SUBSTANCE USE?_____

ALLERGIES TO ANY MEDICATIONS? _____

MEDICATIONS

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_____
( )ALZHEIMER'S DEMENTIA_____
( )MIGRAINES_____
( )DRUG ADDICTION_____
( )ALCOHOL ADDICTION_____
( )OTHER_____

( )MULTIPLE SCLEROSIS_____
( )LUPUS_____
( )RHEUMATOID ARTHRITIS_____
( )OSTEOARTHRITIS_____
( )BLOOD CLOTS_____
( )PARKINSON'S DISEASE_____
( )ESSENTIAL TREMORS_____
( )NEUROPATHY_____
( )MUSCLE DISEASE_____
( )DEPRESSION_____
( )PSYCHOSIS_____

REVIEW OF SYSTEMS

Constitutional: ☐No problems ☐Weight loss ☐Fever ☐Fatigue ☐Poor appetite ☐Night sweats

Skin: ☐No problems ☐Rash ☐Itching ☐Abnormal hair growth ☐Lumps under skin

Eyes: ☐No problems ☐Pain in the eye ☐Red eye ☐Double vision ☐Cataracts ☐Decreased vision ☐Sensitivity to light ☐Dry Eyes

Ears: ☐No problems ☐Ear Ache ☐Decreased hearing ☐Vertigo ☐Loss of balance

Nose: ☐No problems ☐Stuffy nose ☐Pain over sinuses ☐Bleeding from nose ☐Loss of smell sense ☐Runny nose

Throat: ☐No problems ☐Sore throat ☐Ulcers inside mouth ☐Swelling of tongue ☐Difficulty swallowing ☐Dry mouth

Neck: ☐No problems ☐Lumps in neck ☐Painful glands in the neck ☐Pain on turning the neck ☐Stiff neck

Heart: ☐No problems ☐Chest Pain ☐Chest Tightness ☐Palpitations

Lungs: ☐No problems ☐Cough ☐Excessive snoring ☐Wheezing ☐Asthma ☐Chest congestion ☐shortness of breath

Abdomen: ☐No Problems ☐Nausea ☐Vomiting ☐Abdominal pain ☐Diarrhea ☐Blood in stool ☐ constipation

Musculoskeletal: ☐No Problems ☐Joint pains ☐Morning stiffness ☐Joint swelling ☐Low back pain ☐Pain in hands ☐Muscle spasm

Urinary System: ☐No problems ☐Difficulty in urinating ☐Burning in urination ☐Frequent urination ☐Incontinence ☐Blood in urine ☐Kidney stones

Hematologic: ☐No problems ☐Anemia ☐Easy bruising ☐Frequent nose bleeds ☐Blood clots

Neurologic: ☐No problems ☐Dizziness ☐Fainting ☐Seizures ☐Weakness ☐Numbness ☐Tingling ☐Tremors ☐Headaches ☐Falls ☐Unsteady gait ☐Clumsiness of hands ☐Slurred speech ☐Loss of speech ☐Confusion ☐Burning feet

Psychiatric: ☐No problems ☐Depression ☐Poor concentration ☐Anxiety ☐Poor memory ☐Hallucinations ☐Paranoia ☐Suicidal thoughts ☐Panic attacks

Endocrine: ☐No problems ☐Cold Intolerance ☐Heat Intolerance ☐Increased Thirst

Allergy / Immuno: ☐No problems ☐Hay fever ☐Eczema ☐HIV

Vascular: ☐No problems ☐Leg pain while walking ☐Leg ulcers ☐Varicose veins ☐Blood clots ☐Swelling of the legs

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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.

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 services, 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 heath 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 state's public health department.

Other uses and disclosures that 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 heath 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.

Request to inspect protected health information.

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

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, disclosure of my health information, and rights I may have regarding my protected health information.

X_____ (signature of patient)

_____ (date)

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Financial Responsibility
Agreement to Pay

Patient Name: _____

I accept FULL FINANCIAL responsibility from Chester Neurology, PLLC, should my insurance company deny to pay for an entire or a portion of the visit. I understand that I will be required to pay for these services IN FULL.

Patient or legally authorized representative signature:

Signature: _____ **Date:** _____

Missed Appointment and Cancellation Policy

If I am unable to keep my scheduled appointment, I will give at least a 24-hour advance notice to ensure that I will not be charged for the appointment ($25 per missed and/or canceled appointment under 24 hours).

By my signature below I accept these policies.

Signature: _____ **Date:** _____