DALLAS NEUROSCIENCE, P.A.

GURU MOTGI, M.D.
Board Certified in Neurology
Clinical Neurophysiology & Electromyography
3503 W Wheatland Road Suite 200
Dallas Texas 75237
Tel: 214-943-3681 Fax: 214-941-9490

Dear _____

We welcome you to our practice and look forward to seeing you:

Date: _____

Time: _____

Location: _____

Enclosed you will find registration forms which need to be ***completed prior to your appointment.*** In addition, below is a checklist to assist you in preparing for your appointment.

Checklist for your first appointment:

☐ Bring your **Picture I.D, Insurance card, and Medication list** and present to the staff upon arrival.

☐ Important: Bring any diagnostic reports, medical records and referral related to your condition with you to the appointment. This will avoid repeating studies and will assist with your treatment plan. (you can obtain this records from PCP or Referring doctor)

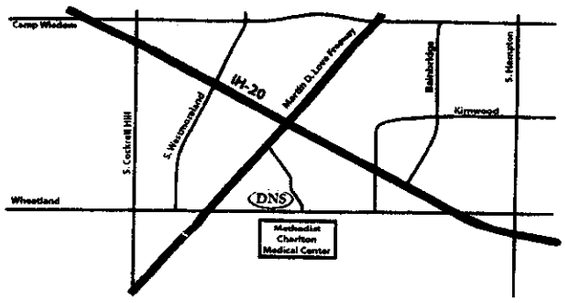
☐ You must arrive on time for your appointment. If you are 15 minutes late for your appointment, please call our office to verify that your appointment can still be accommodated.

PLEASE MAKE SURE ALL PAPERWORK AND DOCUMENTS ARE COMPLETE PRIOR TO YOUR VISIT.

If you have any questions contact our office at **(214) 943-3681**

Office services are payable at the time of service. Payment can be made by Visa, MasterCard, Discover, American Express, Cash or Check

*Map **ONLY** applies for the W. Wheatland Office*



DALLAS NEUROSCIENCE

Guru Motgi, MD

PATIENT INFORMATION

First Name _____ M.I._____ **Last Name**_____

Street Address_____ **Unit/Apt. #**_____

City_____ **State**_____ **Zip Code**_____

Date of Birth _____/_____/_____ Age _____ Marital Status _____

Is the patient living in a nursing home? Yes / No **Email Address**:_____

Home Phone (_____)_____ **Work Phone(**_____)_____

Cell Phone (_____)_____ Sex: F / M **Race**_____

Driver's License Number _____ **Social Security No**: _____

Is this visit related to a work injury? Yes / No Have you filed for Workers' Comp? Y / N

Employer_____ Occupation_____ **Employer Address** _____

Referring Physician_____ Dr.'s Phone(_____)_____

Primary Care Physician_____ Dr.'s Phone(_____)_____

Spouse's Name_____ Date of Birth____/_____/____ S.S.#_____

Spouse's Employer_____ Work Phone(_____)_____

Emergency Contact (**Name/*Relationship***) _____Ph(_____)_____

INSURANCE INFORMATION

Primary Insurance_____ **Ins ID#**_____

Policy Holder: Self / Spouse / Parent / Other_____ Group #_____

Policy Holder: Name_____ S.S. #_____ DOB _____/_____/_____

Claims Mailing Address_____ **Ph(**_____)_____

Secondary Insurance _____ **Ins ID#**_____

Policy Holder: Self / Spouse / Parent / Other_____ Group #_____

Policy Holder: Name_____ S.S. #_____ DOB _____/_____/_____

Claims Mailing Address_____ **Ph(**_____)_____

I hereby assign all medical and / or surgical benefits to Dallas NeuroScience, P.A. I understand that I am financially responsible for all charges, whether paid or not paid by my insurance company. I authorize the physician to release any medical information and / or records, to assist reimbursement from the insurance-company. I also authorize Dr Guru Motgi to provide me with medical treatment.

Patient Signature_____ Date _____/_____/_____

Responsible Party Signature_____ Date _____/_____/_____

Office Use Only

Referring Physician and NPI#_____ UPIN #_____

Referral# /Authorization# _____

Valid dates: _____ #of visits approved: _____

DALLAS NEUROSCIENCE, P.A.

GURU MOTGI, M.D.
Board Certified in Neurology
Clinical Neurophysiology & Electromyography
3503 W Wheatland Road Suite 200
Dallas Texas 75237
Tel: 214-943-3681 Fax: 214-941-9490

Medical Information Release Form
(HIPAA Release Form)

Name: _____

Date of Birth:_____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren) _____

[ ] Other_____

[ ] PCP/Ref MD/Other MD:
_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home _____

[ ] my work no. _____

[ ] my cell no. _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Signed: _____ Date: ____/____/_____
Witness:_____ Date: ___/____/_____

Health History

Dallas Neuroscience
Guru Motgi, MD

Patient Name:_____ Age:_____ Today's Date:_____

DOB:_____ Reason for Today's Visit:_____

Symptoms (Please check symptoms you currently have or have had in the past year)

GENERAL

O Chills
O Depression
O Dizziness
O Fainting
O Fever
O Forgetfulness
O Headache
O Loss of sleep
O Loss of weight
O Nervousness
O Numbness
O Sweats
O Other

MUSCLE / JOINT / BONE

Pain, weakness, numbnes in:

O Arms O Hips
O Back O Legs
O Feet O Neck
O Hands

GENITO-URINARY

O Blood in urine
O Frequent urination
O Painful urination
O Lack of bladder control

GASTROINTESTINAL

O Poor appetite
O Constipation
O Diarrhea
O Indigestion
O Nausea
O Rectal Bleeding
O Stomach pain
O Vomiting
O Other

HEALTH HABITS

Check which substances you use and describe how much you use.

O Caffine _____
O Tabacco _____
O Drugs _____
O Other _____

CARDIOVASCULAR

O Chest pain
O High blood pressure
O Irregular heart beat
O Poor circulation
O Varicose veins
O Swelling of ankles

EAR / EYE / NOSE / THROAT

O Blurred vision
O Difficulty swallowing
O Double vision
O Loss of hearing
O Nosebleeds
O Persistant cough
O Ringing in ears
O Sinus problems
O Other

SKIN

O Bruise easily
O Itching
O Rash
O Scars

CONDITIONS (Check conditions- you currently have or have had in the- past year)

O Aids
O Anemia
O Arthritis
O Asthma
O Breast Lump
O Cancer
O Cataracts
O Diabetes
O Epilepsy
O Heart Disease
O Hepatitis
O High Cholesterol
O HIV Positive
O Kidney Disease
O Liver Disease
O Migraines
O Multiple Sclerosis
O Pacemaker
O Psychiatric Care
O Stroke
O Other_____

Height: _____
Weight: _____

ALLERGIES

_____
_____
_____
_____

FAMILY HISTORY

List any significant health information about your family

_____
_____
_____
_____
_____

HOSPITALIZATIONS

List any hospitalizations you have had, including the year of the hospitalization, hospital, reason for hospitalization, and the outcome

_____
_____
_____
_____
_____
_____
_____

Pharmacy Name:_____

Pharmacy Phone:_____

Medication List
Dallas Neuroscience
Guru Motgi, MD

Name:____

DOB:________________ **Age:**________________

Medication List

Date	Medications	Directions	Prescribing Physician

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Guru Motgi, M.D.
3503 W. Wheatland Rd
#200
Dallas, TX 75237
P214-943-3681 F214-941-9490
www.gurumotgi.com

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ITEM 079-6662/25850 © MAY 2002