Miami Shores Neurology & Sleep Institute, LLC
9999 NE 2nd Ave Suite 208
Miami – Florida, 33138
www.msneurosleep.com
info@msneurosleep.com
PH: 305 754 6240 Fax: 305 754 6255

PATIENT INFORMATION

Patient Personal Information (please fill in all fields)			
PLEASE PRINT CLEARLY			
Last Name:			Primary care Provider (PCP):
First Name:	MI:		Referring Provider (if different than above):
Date of Birth (mm/dd/yyyy):			Sex: ◯ Male ◯ Female
Address:			Marital Status: ◯Single ◯Married ◯Divorced ◯Widow(er)
City:			Social Security Number:
State:	Zip Code:		Employer Name:
Home Phone:	Cellphone:		Employer status: Retired: ◯Yes ◯ No Disabled: ◯ Yes ◯ No
Work Phone:	E-mail:		Student status: ◯ Yes ◯ No

Insurance Policy Holder Information (Guarantor)			
◯ **Same as above:**			
Last Name:	First Name:		MI:
Date of Birth (mm/dd/yyyy):		Social Security Number:	
Home Phone:		Email	
Mailing Address:	City:	State:	Zip Code:
Occupation:		Name of Employer:	
Employers Address:	City:	State:	Zip Code:
Emergency Contact:	Phone #	Relation to Patient: ◯ Self ◯ Spouse ◯ Parent ◯ Other: Specify _____	

Primary Insurance Information		
Name Insurance:		Effective date of Coverage:
Policy Number:	Co-pay:	Group Number/ Group Name:

Secondary Insurance company:		
Name Insurance:	Effective date of Coverage:	Policy Number:

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WE APPRECIATE THE OPPORTUNITY OF SERVING YOU!
WE PLEDGE TO GIVE YOU VERY BEST MEDICAL CARE.

OFFICE POLICY ON PAYMENT:
It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1 ½ percent per month (18 percent annual) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20 percent, including a reasonable attorney's fee.

INSURANCE POLICY
Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy number, address, place of employment and any other pertinent information.
You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:
I authorize the Doctor to release my medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and all times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release information.

I HAVE READ THE ABOVE AND ACCEPT FINANCIAL RESPONSIBILITY IN FULL FOR THIS ACCOUNT

SIGNED	DATE
PATIENT, PARENT, OR GUARDIAN	

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Authorizations and Acknowledgements

1. PRIVACY PRACTICES:

I have been given and have had the opportunity to read a copy of Notice of Patient Privacy Practices. The notice of privacy Practices describe the types and uses of disclosures of my protected health information which might occur in order to expedite medical treatment, payment of medical claims, or facilitate health care operations.

If you would like this office to be able to discuss your medical care with another person or family member, please authorize below.

Name of person we can discuss your care with	Relationship
Signature of patient or parental/legal guardian	Date

2. MEDICARE PATIENTS

I request payment of Medicare benefits to be made either to me or on my behalf to _____ _____ For many services furnished me by that physician/facility. I understand that I am fully responsible for any holder of hospital/facility. I understand that I'm fully responsible for any yearly deductible, co-insurance or charges for non-covered service. I authorize any holder of hospital or medical information about me to release to CMS and its agents any information needed to determine benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature	Date

3. MANAGED CARE (HMO/PPO) PATIENTS

I understand that I'm responsible for all deductibles, co-payments, and charges for non-covered service at the time of my visit. I further understand that should payment from my issuer be denied due to "pre-existing illness exclusion", non-covered service or termination of coverage, that I will be responsible for payment of such services within 10 (ten) days of such notification. If such payment is not received timely then I will be responsible for original full fee and any associated collection costs. It is also my responsibility to notify the office prior to my visit if there is any change in my insurance coverage.

Signature	Date

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MEDICAL RECORDS RELEASE AUTHORIZATION

NAME: _____

DATE OF BIRTH: _____

SS#: _____

I HEREBY AUTHORIZE

Doctor/Facility Name: _____
Phone Number: _____
Fax Number: _____

- ○ All records
- ○ Doctor Notes
- ○ Laboratory/pathology records
- ○ X-ray/radiology records
- ○ Specialist Notes
- ○ Pharmacy/prescription records
- ○ Other (describe specifically)

_____

_____

_____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, Drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

TO RELEASE MY MEDICAL RECORDS TO THE FOLLOWING:

Miami Shores Neurology & Sleep Institute, LLC
9999 NE 2nd Ave Suite 208
Miami, FL 33138
Ph: 305-754-6240 Fax: 305-754-6255

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal Privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My Refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by Law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or Disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit,
Limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient Date

_____
Printed name of patient

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PHOTO CONSENT FORM

I, _____ D.O.B _____

grant permission to Miami Shores Neurology & Sleep Institute, LLC. Dr Margareth A Saldanha, MD. For the use of the photograph(s) or electronic media images as identified below in any presentation of any and all kind whatsoever. I understand that I may revoke this Authorization at any time by notifying Miami Shores Neurology & Sleep Institute, LLC. Dr Margareth A Saldanha, MD in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived.

Name _____

Signature _____ Date _____

Image(s) Description: Patient Photo for Advanced MD PM & EHR Photo.

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I. BASIC INFORMATION

Name: Date of Birth:

Right Hand/Left hand or Both: Age:

II. EDUCATION / LIFESTYLE

Highest Level of Education Completed: ◯ 6th Grade ◯12th Grade ◯ GED ◯ College ◯ Post-Graduate

Hobbies: Are you active with hobbies: ◯ Yes ◯ No Type of Hobby? _____

Exercise: Do you exercise? ◯ Yes ◯ No How often ◯ once a wk. ◯ 2-4d/wk. ◯ >5d/wk.

Diet: Are you on a special diet? ◯ Yes ◯ No If yes, please describe: _____

_____

Home living Situation? ◯ Alone ◯ w/Spouse ◯ w/Spouse/kids ◯ w/Kids ◯ Other: _____

III. SUBSTANCE USE STATUS

Smoke Cigarettes:	◯ Yes ◯ No	If yes, # Packs/day? ◯ 1/2 pk ◯ 1pk◯ >2pk	
Alcohol Use:	◯ Yes ◯ No	If yes, type: ◯ Beer ◯ Wine◯ Hard Alcohol ◯ Other	Drinks per week: ◯ 1 or less◯ 2-4 ◯ >4
Drugs:	◯ Yes ◯ No	If yes, type:	For:
Caffeine Use:	◯ Yes ◯ No	Qty: ◯ 1 or less ◯ 2-4◯ >4	

IV. REASON FOR VISIT

Please check the statement that best describes the main purpose of your visit:

◯ Routine exam provided by the company for which you work

Name of the company _____

◯ Evaluation / management of a problem (briefly describe)

_____

◯ Other purpose (briefly describe)

_____

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V. MEDICATIONS

List below all medications (including nonprescription items and or herbal remedies / supplements which you presently take (also, please bring your pill bottles with you)

Name	Dose and how often taken	Purpose (if known)

VI. VACCINATION / IMMUNIZATIONS (Check and Date)

◯ Pneumovax	◯ Tetanus (last 10 years)
◯ Measles / Mumps / Rubella	◯ Hepatitis

VII. ALLERGIES

Are you allergic to any medication? ◯ Yes ◯ No – If yes, please list the medications and the nature of the allergic reaction. _____

_____

Are you allergic to CONTRAST DYE? ◯ Yes ◯ No – If yes, please describe the allergic reaction:

_____

_____

VIII. OPERATIONS / INJURIES / HOSPITALIZATIONS

Check and date any of the following operations you have had:

◯ Tonsils	◯ Gallbladder	◯ Kidney	◯ Breast
◯ Lungs	◯ Appendix	◯ Prostate	◯ Other
◯ Heart	◯ Intestines (or colon)	◯ Uterus (Hysterectomy)	
◯ Arteries			
◯ Stomach	◯ Hemorrhoids	◯ Spine (or back)	
◯ Ovary	◯ Hernia		

Have you ever had a major injury? ◯ Yes ◯ No, if yes, please briefly describe it, with date(s) and indicate any lasting disability. _____

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IX. PAST MEDICAL DISEASES AND CONDITIONS HISTORY

Have you ever been diagnosed with any of the following diseases or conditions? Please check and date.

◯ Unexplained fever	◯ Angina	◯ Other liver cond.
◯ Unexplained weight loss	◯ Heart murmur	◯ Kidney stones
◯Heart failure	◯ Pancreatitis	◯ Skin disease
◯ Gallstones	◯ Diabetes	◯ Rhythm problem
◯ Goiter	◯ Other heart cond.	◯ Urinary problem
◯ Other thyroid cond.	◯ High blood pressure	◯ STD
◯ Anemia	◯ Phlebitis/blood clots	◯ Pelvic Infection
◯ Other blood cond.	◯ Varicose veins	◯ Prostate disease
◯ Glaucoma	◯ Nervous stomach	◯ Arthritis
◯ Cataracts	◯ Hiatal hernia	◯ Tendinitis/bursitis
◯ Ear condition	◯ Ulcer	◯ Gout
◯ Hay fever	◯ Diverticulosis	◯ Depression
◯ Asthma	◯ Colitis	◯ Other mental illness
◯ Pneumonia	◯ Intestinal Polyps	◯Epilepsy/Seizure
◯ Tuberculosis	◯ Hemorrhoids	◯ Cancer (location/date)
◯ Emphysema	◯ High cholesterol	
◯ Other lung cond.	◯ Hepatitis	◯ Other
◯ Heart attack	◯ Cirrhosis	

X. FAMILY HISTORY

If parents, brothers, sisters, children have had any of the following health problems, please check and list which relatives.

◯ Arthritis	◯ Heart disease	◯ Mental cond.
◯ Diabetes	◯ High blood pressure	◯ Conditions as yours
◯ High cholesterol	◯ Stroke	◯ Tuberculosis
◯ Allergies / Asthma	◯ Cancer	◯ Other
◯ Kidney disease	◯ Epilepsy	

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FAMILY HISTORY				
Father:	○ Alive	○ Deceased	○ Healthy	○ Medical problems:
Mother	○ Alive	○ Deceased	○ Healthy	○ Medical problems:
Brother (s):	# Brothers: (		○ Healthy	○ Medical problems:
Sister(s):	# Sisters: (		○ Healthy	○ Medical problems:
Sons(s):	# Sons: (		○ Healthy	○ Medical problems:
Daughter(s):	# Daughters: (		○ Healthy	○ Medical problems:

XI. TO BE ANSWERED BY WOMEN ONLY

Number of pregnancies:	Are your periods regular?	◯ Yes ◯ No
Number of deliveries:	Do you have bleeding between your periods?	◯ Yes ◯ No
Pregnancy related complications:	Any possibilities of current pregnancy?	◯ Yes ◯ No
Date last menstrual period began?	Do you have vaginal discharge?	◯ Yes ◯ No
Date of last pelvic exam and pap test	Have you noticed any lumps in your breast	◯ Yes ◯ No
Date of your last mammogram	Have you had any vaginal bleeding since menopause?	◯ Yes ◯ No
If you are past menopause, age at which your last period occurred	Do you have hot flashes?	◯ Yes ◯ No

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REVIEW OF SYSTEM

Please check any symptom, condition or problems in the areas listed below, and describe details of the problems if present in patient.

REVIEW OF SYSTEMS – GENERAL			
CONSTITUTIONAL	**EARS,NOSE MOUTH, THROAT**	**CARDIOVASCULAR**	**BLOOD/ENDOCRINE/LYMPHATIC ALLERGIC**
☐ Altered taste/smell	☐ Balance problem	☐ Chest palpitations	☐ Blood disorder
☐ Change in appetite	☐ Dizziness	☐ Chest pain	☐ Sickle Cell Disease
☐ Weight loss or gain	☐ Ringing in ears	☐ Chest pressure	☐ Enlarged lymph nodes
☐ Unable to sleep	☐ Hearing loss	☐ Fainting	☐ HIV exposure
☐ Excessive sleepiness	☐ Trouble breathing through nose	☐ Heart Failure	☐ Thyroid Disease
☐ Fatigue	☐ Nose bleeds/ discharge	☐ Heart Murmur	☐ Diabetes
☐ Recurrent fevers	☐ Sinus disease	☐ High blood pressure	☐ Weak bones
☐ Feeding problems	☐ Mouth sores	☐ Low blood pressure	☐ Growth problems
☐ Toilet training problems	☐ Sore throat	☐ Shortness of breath	☐ Anemia
☐ Food intolerance	☐ Trouble swallowing	☐ Lew swelling	☐ Transfusions
MUSCULOSKELETAL	**EYES**	**GASTROINTESTINAL**	**RESPIRATORY**
☐ Low back pain	☐ Blurred vision	☐ Abdominal pain	☐ Bronchitis
☐ Neck pain	☐ Double vision	☐ Constipation	☐ Wheezing
☐ Joint pain	☐ Glaucoma	☐ Diarrhea	☐ Pneumonia
☐ Joint swelling	☐ Cataracts	☐ Gastritis	☐ Tuberculosis
☐ Broken bones	☐ Decreased vision	☐ Liver disease/hepatitis	☐ Chronic cough
SKIN	**PSYCHIATRIC**	☐ Colic	**GENITOURINARY**
☐ Rashes	☐ Anxiety	☐ Bloody stools	☐ Increased frequency
☐ Hair problems	☐ Depression	☐ Ulcer	☐ Kidney stones
☐ Nail problems	☐ Attention problems	☐ Vomiting	☐ Bloody urine
REVIEW OF SYSTEMS - NEUROLOGIC			
☐ Confusion	☐ Clumsiness	☐ Choking	☐ Behavior/emotional
☐ Spells	☐ Facial numbness/tingling	☐ Difficulty chewing	☐ Withdrawn
☐ Dizziness	☐ Numbness – arms (L/R/B)	☐ Difficulty tasting	☐ Aggressive
☐ Hallucinations	☐ Numbness – legs (L/R/B)	☐ Drooling	☐ Hyperactivity
☐ Headache	☐ Abnormal movements	☐ Hoarseness	☐ Mood swing
☐ Sleepiness	☐ Poor coordination	☐ Incontinence – bowel	☐ Temper tantrums
☐ Memory problems	☐ Speech difficulty	☐ Incontinence –	☐ Breatholding spells

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		bladder	
☐ Personality change	☐ Stiffness	☐ Nausea	☐ Suicidal thoughts
☐ Abnormal head size	☐ Trouble walking	☐ Pain	☐
☐ Abnormal head shape	☐ Weakness – arms (L/R/B)	☐ Snoring	☐
☐ Trouble concentrating	☐ Weakness – legs (L/R/B)		☐

Other symptoms: (please describe) _____

_____

_____

_____