

Irfan Lalani, MD, PA

Interventional Pain, Neurodiagnostics and Rehabilitation

New Patient Form

Neurology

Methodist Sugar Land Hospital

Medical Office Building 3

16605 S.W. Freeway, Suite 320

Sugar Land, TX 77479

Ph: (281) 265-0225 Fax (281) 265-2219

Patient Information

First Name: _____ Middle Name/Initial: _____

Last Name: _____ DOB: _____ Gender: Female Male

Street Address: _____ City: _____ State: _____ Zip: _____

SSN#: _____ Home Phone#: _____ Cell Phone #: _____

Work Phone #: _____ Alternate Phone #: _____

Primary Insurance Information

Insurance Company Name: _____

Policy/Member #: _____ Group/Account #: _____ SSN#: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Phone Number #: _____ (Located on the card)

Subscriber's Full Name: _____ Subscriber's DOB: _____

Relationship to the Subscriber: _____

Secondary Insurance Information

Insurance Company Name: _____

Policy/Member #: _____ Group/Account #: _____ SSN#: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Phone Number #: _____ (Located on the card)

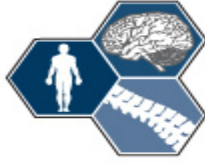
Subscriber's Full Name: _____ Subscriber's DOB: _____

Relationship to the Subscriber: _____

Pharmacy Information

Name: _____ Phone#: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____



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Emergency Contact (Not living with you)

Contact Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____ Alternate Phone #: _____

Doctors

Do you have a Primary Care Doctor: Yes No If yes, Primary Care Doctor Name: _____

If No, would you like us to refer you to a Primary Care Doctor: Yes No

How did you find out about us? Referred by Doctor _____

Internet _____ Friend _____ Magazine _____

Methodist Spine Center Hospital ER _____ Other _____

Patient History

Principal Reason for seeing Dr. Lalani: _____

How long have you had this problem: _____

Any Other Neurological Issues: _____

Social History

Status: Married Single Divorced Separated Widowed

Occupation Status: Employed Full Time Employed Part Time Disabled Retired

Employer/Company Name: _____ Occupation/Job Title: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

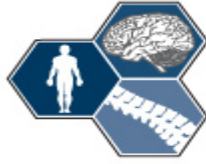
Student: Yes No Name of Institution: _____

Tobacco Smoker: Yes Current Smoker No, Former Smoker No, Non-Smoker

Do you drink alcohol? Yes : How much? _____ No, Never

Have you ever used illicit drugs: Yes No Have you used illicit drugs within the past year: Yes No

History of Addiction: Yes No



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Patient Medical History

Please mark any conditions for which you have been treated:

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Disease or Chest Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Lung Disease/Asthma/COPD | <input type="checkbox"/> Migraine/Chronic headache | <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Liver Disease/Hepatitis/Cirrhosis | <input type="checkbox"/> Alcoholism/Addiction | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Other |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Psychiatric Condition | _____ |

Allergies/Intolerance

Please list all medications that you are allergic to and describe the reaction:

Medication	Reaction

Family History

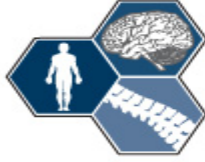
Do you have a family history of any of these following conditions?

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Disease or Chest Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Lung Disease/Asthma/COPD | <input type="checkbox"/> Migraine/Chronic headache | <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Liver Disease/Hepatitis/Cirrhosis | <input type="checkbox"/> Alcoholism/Addiction | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Other |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Psychiatric Condition | _____ |

Review of Symptoms

Please mark the symptoms that you have experienced in the last 6 months:

- | | | | | | |
|--|--|---------------------------------------|---|---|--------------------------------------|
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Double vision | <input type="checkbox"/> Depression | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Poor balance/falls | <input type="checkbox"/> Easy bleeding/bruising | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Itching | <input type="checkbox"/> Rash | <input type="checkbox"/> Shaking/tremors | <input type="checkbox"/> Repeated infections | <input type="checkbox"/> Weight loss |



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Consent Form:

Treatment Authorization: I authorize Irfan Lalani, MD PA to examine, diagnose and treat me. I authorize and give Irfan Lalani, MD PA consent to submit specimens of blood, urine, tissue, etc. to the laboratory (ies) of choice for analysis and study and to include diagnosis for submission for payment to the insurance carrier for the named patient.

Authorization for Release of Information: I hereby authorize Irfan Lalani, MD PA to release any information necessary to my insurance company, including governmental health care insurer, such as Medicare and Medicaid or other health care practitioners involved in the care of the named patient. I understand that I am giving this authorization only in the care of a subpoena or for the release of information necessary for the provision of continuity of care to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost efficiency of care. I also authorize the release of all my medical records, including but not limited to, imaging, labs, office notes, Rx history and other medical information relevant to my care.

Responsible Party Agreement: I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered including supplies or pharmaceuticals that are provided to me in my treatment. If any charges are submitted to my insurance carrier by either Irfan Lalani, MD PA or by a provider of healthcare services, products, or equipment which are ordered by my physician for the care of the named patient and there services are not covered medical services. I agree to pay for any balance deemed applicable according to my insurance and that I agree to make payment for these amounts at the time of service. If I am not covered by any insurance carrier, I agree to pay for services rendered at the time of service.

Acknowledgement of Review of Notice of Privacy Practices: I have reviewed this Office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

I, _____, have read and agree to the consent form above by proof of my signature below.

Signature of Patient or Legal Representative

Date

Nurse Section

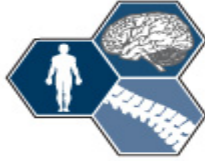
Vitals Signs

Current Weight: _____

BP: _____

Height: _____

HR: _____



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Fax: (281) 265-2219

Medical Records Request Form

Authorization For Disclosure of Health Information

This is a request for medical records for the following patient:

Patient Name: _____

Patient Address: _____

Patient DOB: _____

Patient SSN: _____

Information to be disclosed:

- | | |
|--|--|
| <input type="checkbox"/> ALL MEDICAL RECORDS ON FILE | <input type="checkbox"/> All Laboratory Tests |
| <input type="checkbox"/> All Imaging and Radiology | <input type="checkbox"/> All History and Physicals |
| <input type="checkbox"/> All Progress Notes | <input type="checkbox"/> All Current Medications |
| <input type="checkbox"/> All EMG Tests | <input type="checkbox"/> Other _____ |

Information to be disclosed to:

Irfan Lalani, MD, PA
Neurology and Pain Medicine
16605 Southwest Freeway Suite #320
Sugar Land, TX 77479
Phone: (281) 265-0225
Fax: (281) 265-2219

I, _____, do hereby authorize the release of all my medical records to Dr. Irfan Lalani and staff.

Signature of Patient or Qualified representative

Date

