PATIENT REGISTRATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

ADDRESS	CITY	STATE	ZIP

(______) HOME PHONE	(______) WORK PHONE	(______) ALTERNATE PHONE

SOCIAL SECURITY #	DATE OF BIRTH	AGE	SEX (M / F)

OCCUPATION	EMPLOYER'S NAME	(______) EMPLOYER'S PHONE #

MARITAL STATUS: MARRIED / PARTNERED / DIVORCED / WIDOWED / SINGLE / CHILD

SPOUSE / SIGNIFICANT OTHER'S NAME	SS #	DOB

RELATIVE NOT LIVING WITH YOU	RELATIONSHIP	(______) PHONE

RELEASE OF INFORMATION STATEMENT

I hereby authorize Dr. William S. Gilmer to release or obtain any and all medical information required in the course of my care. This disclosure may include HIV test results, psychiatric or psychological records or any other information relating to the diagnosis, treatment or therapy of my disease, illness or condition.

I assign to Dr. Gilmer all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by insurance. I release Dr. Gilmer, his employees and agents from liability for following this authorization and request.

I have received a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

SIGNATURE	DATE

WILLIAM S. GILMER, M.D., F.A.A.N.

NEUROLOGY, EMG, EEG

Plaza Medical Center
1200 Binz, Suite 1270
Houston, Texas 77004
713-520-5155 Fax 713-520-8531

We would like to use email, text or voicemail to leave you messages, appointment reminders, and give you access to your own secure personal health record. If you do not have an email or cellphone, write "None".

If you designate someone else to receive these notices, indicate their relationship to you.

Email:____

Cell phone: ____

Home phone: ____

Your current **local Pharmacy** name, phone and location (City, phone, street, Zip)

Local:____

Mail order pharmacy plan: name, phone, location:

Mail order: ____

Ethnicity: (circle one)
Non-Hispanic
Hispanic

Preferred language:_________________________

Race: (Circle one)
African-American or African-American,
Asian or Asian American,
Caucasian or European American,
Native American or native Alaskan,
native Hawaiian or other Pacific Islander,
other race.

____

Signature and date
registration p2 email, pharm 1/2/15

WILLIAM S. GILMER, M.D., P.A.

NEUROLOGY, EMG, EEG

PLAZA MEDICAL CENTER
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Dear Patients,

We would like to thank you for being a patient in our office. We value all of our patients and strive to provide the best possible care in the most comfortable setting.

Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved time to another patient who is in need of it.

We know that your time is valuable. When your appointment is made, a room is reserved and your records are prepared for your visit. The best way to cancel/reschedule an appointment is via phone.

There is a $50.00 charge for not showing up for scheduled appointments OR rescheduling less then 24 hours. This fee will be due prior to scheduling your next appointment. Understand that Insurance will not cover this for you. ***Repeated cancelations or missed appointments will result in loss of future appointment privileges.***

Thanks you very much for your understanding. Please call us at 713-520-5155 should you have any questions.

Sincerely,

Dr. William Gilmer MD PA

Print:________________________

Sign:________________________

Date: ____________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone ______________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone ______________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to fax to this number
- ☐ Other ______________________

______________________________ Patient Signature

______________ Date

______________________________ Print Name

______________ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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Patient Name

We may need to review records and test results done by other doctors in the course of your care, and we may need to send them a report in return. Please provide us with the following information.

Primary Care Physician (PCP) name, address, phone if available

Referring Physician (if different) name, address, phone if available

List all the other Physicians you are currently seeing and why (name, address, phone if available)

What tests, labs or other doctor's evaluations have you already had in trying to evaluate or treat the problem you are here for today? List where they were done, or who would have the results.

MRI scan, CAT scan, Brain scan, X-rays

EEG, EMG / NCV, other tests of nerves

Blood tests done in the last 12 months

Other Neurological evaluations

PATIENT MEDICATION LOG

Patient Name: ____________________ Phone #: ____________________

Pharmacy Phone #: ______________ Mail Order or Local Pharmacy:

Drug Allergies and What reaction : ____

____

Date	Medication	Strength/mg Per Pill	When Taken	What is it For?	# Use per month	Name of Prescribing Doctor	Do you need Refills?

NAME ______________________ **DATE** ______________________

AGE ________ **Right / Left handed** **Who is your PRIMARY Dr.?** ______________________
Who referred you here? ______________________

What other Doctors do you see:

Physician Name:	**Specialty:**	**Physician Phone:**	**Physician Fax:**

Please give all **test results, forms or paperwork** you have today to our staff - **NOW.**
If you have had testing, *but did not bring copies with you*, **please tell our staff NOW,** so that we can request the results and discuss them together.

For this problem have you had ☐ MRI ☐ CAT scan ☐ EEG ☐ EMG ☐ blood tests ☐ x-rays ☐ other tests ☐ ER visits ☐ hospitalizations ☐ operations ☐ other Dr. visits ☐ seen other neurologists?

____

____

HISTORY

Bp: P:
Ht: Wt.

What is the **problem or condition** that brought you here today?

____

____

____

____

____

How long has this been "**bad**" or severe? ______________________

When was the **very first time** you ever experienced a symptom or problem like this one? ______________________

What makes it **worse** (stress, certain foods, lack of sleep, etc.)? ______________________

____

What makes it **better** (medications, rest, exercise, etc.)? ______________________

____

Drugs **previously tried** for principal complaint, but **Not** currently taking:

Name, dose frequency, how long tried:	Reason for stopping:	Prescribing Physician:

Attach additional page if needed.

PAST MEDICAL HISTORY

Do you have: ______**NONE APPLY TO ME**

___diabetes
___high sugar
___high cholesterol
___blood disease
___high blood pressure
___low blood pressure
___heart disease
___heart attack
___stroke or tia

___asthma
___anemia
___hepatitis
___liver disease
___ kidney disease
___dialysis
___lupus
___thyroid problems
___glaucoma

____ obstructive sleep apnea
____use CPAP? Yes Or No ?
____seizures or epilepsy
____migraine
____Alzheimer's
____depression
_____ anxiety
____bipolar

___HIV+? T-cells=_____ viral load=______ lowest T-cells ever=_______

List any other **MEDICAL DIAGNOSES** ____
____
____
____
____

SURGERIES: please list when (year) and what for? **NO SURGERIES**_________
____
____
____
____

Depression Screen:

Yes/No Over the past two weeks have you felt down, depressed or hopeless?
Yes/No Over the past two weeks have you had little pleasure in normal activities?

FAMILY HISTORY

List diseases that run in your **immediate family** (parents, brother/sister, children):
____
____
____

family members with the following? Indicate who (**father / mother / sibling / children**)

Heart attacks_______________________________
Strokes ____________________________________
Diabetes___________________________________
High blood pressure__________________________
Lupus, ____________________________________
Depression/Anxiety __________________________
Bipolar disorder ____________________________

Alzheimer's _______________________________
Seizures or Epilepsy _________________________
Migraine __________________________________
Parkinson's disease___________________________
Tremors ________ ___________________________
Schizophrenia_ ______________________________

Patient Name ______________________________

SOCIAL HISTORY

What do you do for a living?_______________________________
Who else lives with you? _____________________________________ I live alone____
Do you have a living will or directive to physicians? **Yes / No**
Do you have a power of attorney for health care? **Yes / No** Who is your POA?____________________
Are you single / married / divorced / widowed / partnered with a man / partnered with a woman

Tobacco – average daily use now___________ NEVER smoked____ Used to smoke until___________
Alcohol – average daily use now___________ NEVER drank____ Used to drink until___________
Caffeine – average daily use now___________ NONE___
Exercise – how many times a week___________
Sexual – are you sexually active? **Yes / No** with men / women / both

YOUR REVIEW OF SYSTEMS

Circle other symptoms or complaints that **you personally** have problems with now

CONSTITUTIONAL
Unexpected weight loss
Excess daytime sleepiness

EYES
double vision

EARS, NOSE THROAT
hearing loss, cough

CARDIOVASCULAR
Blackouts, chest pain, angina
irregular heartbeats

RESPIRATORY
short of breath,

STOMACH
nausea, vomiting
bloody stools

GENITAL-URINARY
Can't control bowels or urine

MUSCULOSKELETAL
neck pain, low back pain
muscle cramps

SKIN
rash, lumps

ENDOCRINE
Hormone problems, thyroid

HEMATOLGIC
blood transfusions

IMMUNOLOGIC
seasonal allergies

PSYCHOLOGIC
Nervous, anxiety, insomnia
Depression, crying spells, mood swings
Suicide thoughts
current stress level 1 – 10 = ______

NEUROLOGIC
headaches, migraine, faint, seizure memory loss,
numbness, weakness, coordination loss,
snoring, irregular breathing in sleep,

Patient Name ____________________