Comprehensive Neurology Clinic

Refaat El-Said, MD
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Phone: 407-208-0708
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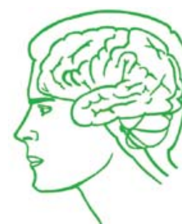

Dear New Patient,

Welcome to our office. We now have two locations. Please make note of your appointment day, time, and location.

Appointment ___________________________ (date) at ____________________ (time)

Location: ( ) 10967 Lake Underhill Road, Suite 148, Orlando, FL 32825

( ) 3232 Hillsdale Lane, Kissimmee, FL 34741

Please bring the following items with you to your appointment.

Patient Registration Form – completed
Patient History Form – completed
Insurance Card
Driver's License
Medical records
Physician referral forms – if required by insurance
MRI and CT reports – if any
MRI and CT films or CDs – if any
List of your current medications

If you cannot keep this appointment, please provide at least 48 hours notice to our office. Otherwise, missed appointments may incur a $50 fee. Thank you for your cooperation.

Sincerely,

The staff of Comprehensive Neurology Clinic
www.CNC-Neurology.com

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Patient Registration Form

Today's Date: __________________________________ Date of Birth: ________________

Patient's Name: ________________________________ Age: _____________________ ( )Male ( )Female

Address: ______________________________________ City: _____________________ State: ___ Zip: _____

Social Security #: _______________________________ Driver's License #: ____________________________

Home Phone: ____________________ Cell: _____________________ Work Phone: ____________________

Marital Status: ___________________ E-mail Address: ____

Employer: _______________________ Phone: ___________________ Address: _______________________

Emergency Contact 1: ___________________________ Relationship: _______ Phone: __________________

Emergency Contact 2: ___________________________ Relationship: _______ Phone: __________________

Primary Care Physician: __________________________ Phone: ______________________________________

Address: ______________________________________ City: _____________________ State: ___ Zip: _____

Referring Physician: _____________________________ Phone: ______________________________________

Address: ______________________________________ City: _____________________ State: ___ Zip: _____

Patient's Primary Insurance

Name of Insurance: ____

Policy #/ID #: ____ Group #: ______________________________

Policyholder's Name: __________________________________ Date of Birth: __________________________

Social Security #: ____________________________________ Relationship to patient: _________________

Patient's Secondary Insurance

Name of Insurance: ____

Policy #/ID #: _______________________________________ Group #: ______________________________

Policyholder's Name: _________________________________ Date of Birth: __________________________

Social Security #: ____________________________________ Relationship to patient: _________________

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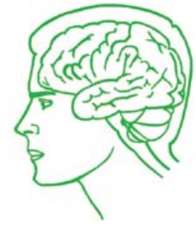


Patient History Form

Name: ______________________________ Date of Birth: ____________________

Drug Allergies: ( )Yes ( )No List: ____

Medications currently being used (including non-prescription drugs taken regularly):

Name of Drug	Dose	How often

Have you had any hospitalizations or surgeries (not including pregnancies)? ( )Yes ( )No If yes, list below.

Date	Diagnosis	Treatment	Doctor	Hospital

Personal and Family Medical History:

Medical Condition	Self	Family	Relationship	Maternal or Paternal?
Heart Problems	( )Yes ( )No	( )Yes ( )No		( )M ( )P
High Blood Pressure	( )Yes ( )No	( )Yes ( )No		( )M ( )P
Cancer	( )Yes ( )No	( )Yes ( )No		( )M ( )P
Diabetes	( )Yes ( )No	( )Yes ( )No		( )M ( )P
Stroke	( )Yes ( )No	( )Yes ( )No		( )M ( )P
Depression or Suicide	( )Yes ( )No	( )Yes ( )No		( )M ( )P
Asthma	( )Yes ( )No	( )Yes ( )No		( )M ( )P
Sleep Problems	( )Yes ( )No	( )Yes ( )No		( )M ( )P
Other:	( )Yes ( )No	( )Yes ( )No		( )M ( )P

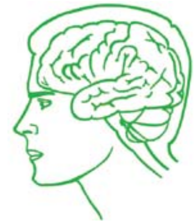
Marital Status: __________________________ Number of children: ______________

I drink alcoholic beverages __________ times per day, __________ times per week.

I smoke __________ cigarettes (or pipes, or cigars) per day.

Have you ever used recreational or street drugs? ( )Yes ( )No What & When: ________________

Is your condition related to a work accident or injury? ( )Yes ( )No
Is your condition related to an automobile accident? ( )Yes ( )No
Have you seen an attorney regarding your condition? ( )Yes ( )No
Have you seen any other neurologist? ( )Yes ( )No If yes, who? ____________________



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Medical Records Release & Insurance Assignment

Name of Patient: ____ Date of Birth: ________________

I authorize the release of medical records to Comprehensive Neurology Clinic from other healthcare providers for the purpose of diagnosis, treatment, and continued care. Further, I release all applicable healthcare providers from all responsibility and/or liability that may arise from this authorization.

Initials: ___________

I authorize Comprehensive Neurology Clinic to release any medical information and records concerning diagnosis and treatment to any third party, insurance company, or government agency for the purpose of processing claims and payment.

Initials: ___________

I authorize Comprehensive Neurology Clinic to release medical records to healthcare providers involved in continuing care and treatment.

Initials: ___________

I authorize payment of insurance benefits directly to Comprehensive Neurology Clinic for services rendered and release any medical information necessary to process claims. I am responsible for co-payments, non-covered services, and deductible amounts. I am responsible to supply Comprehensive Neurology Clinic with the most current insurance information and any changes to insurance coverage prior to services rendered. I am responsible to obtain a referral or authorization from the Primary Care Physician, if required by insurance.

Initials: ___________

I permit a copy of these authorizations and assignments to be used in place of this original form.

Initials: ___________

I release Comprehensive Neurology Clinic from all responsibility and/or liability that may arise from this authorization.

Initials: ___________

This release and assignment remains in effect for one (1) year, or until revoked in writing by the patient or responsible party.

Initials: ___________

Signature of Patient or Responsible Party: ____

Printed Name: ____ Date: ________________________

Relationship to Patient: ________________________________