**Neurology Associates of Central Jersey, LLC**

670 North Beers Street Building 2, Suite 4 Holmdel, NJ 07733 • Phone: 732.788.6537 • Fax: 732.254.1558

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| **PATIENT INFORMATION** (Section I) | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Name:** | |  | | | | | | | | | | | | | | | | | | | |  | **Marital Status:** | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | |  | Married | |
| **City:** |  | | | | | | | | | **State:** | | | | |  | **Zip:** | | |  | | |  | Single | |
| **Email Address:** | | | | | |  | | | | | | | | | | | | | | | |  | Divorced | |
| **Date Of Birth:** | | | | |  | | | | | | **Sex:**  Male  Female | | | | | | | | | | |  | Separated | |
| **Social Security Number:** | | | | | | | | |  | | | | | | | | | | | | |  | Widowed | |
| **Home Phone #:** | | | | | |  | | | | | | | | **Cell Phone #:** | | | |  | | | | | | |
| **Work Phone #:** | | | | | |  | | | | | | | | **Alt Phone #:** | | | |  | | | | | | |
| **Employer:** | | | |  | | | | | | | | | | | | | | | | | |  | **Student:** | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | |  | Yes  No | |
| **City:** |  | | | | | | | | | **State:** | | | | |  | **Zip:** | | |  | | |  | **Retired:** |
|  | | | | | | |  | | | | |  | | | | |  | | | | |  | Yes  No |
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| **FINANCIAL RESPONSIBILITY** (Section II) **(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT NAMED ABOVE)** | | | | | | | | | | | | | | | | | | |  | | **CHECK HERE IF “SELF” & PROCEED TO SECTION 3** | | | |
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| **Name:** | |  | | | | | | | | | | | | | | | | | | | |  | **Relationship:** | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | |  | Spouse | |
| **City:** |  | | | | | | | | | **State:** | | | | |  | **Zip:** | | |  | | |  | Parent | |
| **Email Address:** | | | | | |  | | | | | | | | | | | | | | | |  | Legal Guardian | |
| **Date Of Birth:** | | | | |  | | | | | | **Sex:**  Male  Female | | | | | | | | | | |  | Other (Specify) | |
| **Social Security Number:** | | | | | | | | |  | | | | | | | | | | | | |  |  | |
| **Home Phone #:** | | | | | |  | | | | | | | **Cell Phone #:** | | | | |  | | | | | | |
| **Work Phone #:** | | | | | |  | | | | | | | **Alt Phone #:** | | | | |  | | | | | | |
| **Employer:** | | | |  | | | | | | | | | | | | | | | | | | | | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | | | | |
| **City:** |  | | | | | | | | | **State:** | | | | |  | | | **Zip:** | |  | | | | |
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| **EMERGENCY CONTACT** (Section III) | | | | | | | | | | | | | | | | | | | | | | | | |
| **Contact Name:** | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Relationship:** | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Contact Phone #(s):** | | | | | | | |  | | | | | | | | | | | | | | | | |
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## **FOR OFFICE USE ONLY:** Appointment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Demos Rec’vd On:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Insurance Setup 🞎 Patient History Entered

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| **PHARMACY INFORMATION** (Section IV) | | | | | | | | | | | | | | | | | | | | | |
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| **Name Of Pharmacy:** | | | | | | | **Zip Code or Street Address:** | | | | | | | | | | **Pharmacy Phone:** | | | | **Pharmacy Fax:** |
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| **PRIMARY INSURANCE INFORMATION** (Section V)  **(GIVE CARD TO RECEPTIONIST UPON ARRIVAL)** | | | | | | | | | | | | | | | | | | | | | |
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| **Insurance Company:** | | | |  | | | | | | | | | | | | | |  | Relationship to Insured: | | | |
| **Claims Address:** | |  | | | | | | | | | | | | | | | |  | Spouse | | | |
| **City:** |  | | | | | | | | | **State:** |  | | **Zip:** | | |  | |  | Parent | | | |
| **Phone # for Providers/Eligibility & Benefits:** | | | | | | | | | | | |  | | | | | |  | Legal Guardian | | | |
| **Member Number:** | | |  | | | | | | | | | | | | | | |  | Other (Specify) | | | |
| **Group Number:** | | |  | | | | | | | | | | | | | | |  |  | | | |
| **Insured’s Full Name:** | | | |  | | | | | | | | | | | | | |
| **Insured’s Social Security No.:** | | | | | | | | |  | | | | | | | | |
| **Insured’s Date Of Birth:** | | | | |  | | | | | | | | | | | | |
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| **SECONDARY INSURANCE INFORMATION** (Section VI)  **(GIVE CARD TO RECEPTIONIST UPON ARRIVAL)** | | | | | | | | | | | | | | | | | | | | | |
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| **Insurance Company:** | | | |  | | | | | | | | | | | | | |  | Relationship to Insured: | | | |
| **Claims Address:** | |  | | | | | | | | | | | | | | | |  | Spouse | | | |
| **City:** |  | | | | | | | | | **State:** |  | | **Zip:** | | |  | |  | Parent | | | |
| **Phone # for Providers/Eligibility & Benefits:** | | | | | | | | | | | |  | | | | | |  | Legal Guardian | | | |
| **Member Number:** | | |  | | | | | | | | | | | | | | |  | Other (Specify) | | | |
| **Group Number:** | | |  | | | | | | | | | | | | | | |  |  | | | |
| **Insured’s Full Name:** | | | |  | | | | | | | | | | | | | |
| **Insured’s Social Security No.:** | | | | | | | | |  | | | | | | | | |
| **Insured’s Date Of Birth:** | | | | |  | | | | | | | | | | | | |
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| **HOW DID YOU HEAR ABOUT US?** (Section VII) | | | | | | | | | | | | | | | | | | | | | |
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| Referred by Physician - Physician’s Name: | | | | | | | | | | | |  | | | | | | | | | |
| Phone: | | | | | | | | | | | |  | | | | | | | | | |
| Fax: | | | | | | | | | | | |  | | | | | | | | | |
| Internet Website or Search Engine –Which site did you initially find us on? | | | | | | | | | | | | | | | | | |  | | | |
| Newspaper/Magazine Article Or Ad – Which publication? | | | | | | | | | | | | | |  | | | | | | | |
| Insurance Plan (Check here if you found us thru your insurance plan’s website or in their provider directory.) | | | | | | | | | | | | | | | | | | | | | |
| Friend or Family Member: | | | | | | | |  | | | | | | | | | | | | | |
| Other – Please describe: | | | | | |  | | | | | | | | | | | | | | | |

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| **REFERRING PHYSICIANS** (Section VIII) | | |
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| **Physician Name:** | | **Physician Phone Number:** |
| **Referring Physician:** |  |  |
| **Primary Care Physician:** | ­ |  |
| **Other Physicians:** |  |  |
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| **PATIENT HISTORY** (Section IX) | | | |

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| **Current Medications (Please Attach Another Page If Needed)** | | | | | | | | | | | | |
|  | **Name, Dose and Frequency:** |  | **Reason For Medication:** | | |  | | **Prescribing Physician:** | | | | |
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| **Drugs Previously Tried For Principal Complaint But Not Currently Taking** | | | | | | | | | | | | |
|  | **Name, Dose and Frequency:** |  | **Reason For Stopping:** | | |  | | **Prescribing Physician:** | | |  | |
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| **Drug Allergies And Adverse Reactions (Please Attach Page If Needed)** | | | | | | | | | | | | |
|  | **Name and Dose:** |  | **Description of Adverse Reaction:** | | | | | | |  | |
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| **PAST MEDICAL HISTORY** (Section X)  **(ATTACH ADDITIONAL PAGE IF NEEDED)** | | | | | | | | | | | |
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|  | **Other Medical Conditions:** | | |  | **Date Of Onset:** | |  | | **Treating Physician:** |  | |
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|  | **Past Surgeries:** | | |  | **Date Performed:** | |  | | **Operating Physician:** |  | |
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|  | **List any diseases that run in your immediate family (Parents, Brother, Sisters, Children):** |  |
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|  | **Does anyone in your immediate or extended family have the same condition or symptoms for which you are seeing Dr. Gandhi? If so, who?** |  |
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|  | **Is there any other information you would like to tell us?** |  |
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**Neurology Associates of Central Jersey, LLC**

670 North Beers Street Building 2, Suite 4 Holmdel, NJ 07733 • Phone: 732.788.6537 • Fax: 732.254.1558

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| **PATIENT NAME:** | |  |
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| **Treatment Authorization**  **(Check and sign the applicable paragraph)** | | |
|  | | |
|  | I authorize Neurology Associates of Central Jersey, LLC to examine, diagnose and treat me. I authorize and give Neurology Associates of Central Jersey, LLC to include diagnosis for submission for payment to the insurance carrier for the named patient. | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE OF PATIENT DATE DATE | |
|  | | |
|  | I hereby authorize Neurology Associates of Central Jersey, LLC to examine and treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of patient). I authorize and give Neurology Associates of Central Jersey, LLC my consent to include diagnosis for submission for payment to the insurance carrier for the named patient. | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE OF PATIENT REPRESENTATIVE DATE DATE | |
| **Responsible Party Agreement** | | |
| I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are provided to me in my treatment. If any charges are submitted to my insurance carrier by either Neurology Associates of Central Jersey, LLC or by a provider of healthcare services/products/ equipment which are ordered by my physician for the care of the named patient and these services are not covered medical services, I agree to pay for any balance deemed applicable according to my health insurance rules and regulations. I hereby agree that I am responsible for the payment of any co- payment, deductible and co-insurance and that I agree to make payment for these amounts at the time of service. If I do not have insurance coverage, I agree to pay for services rendered at the time of service.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE OF PATIENT OR REPRESENATIVE DATE | | |
| **E-Mail Message & Text Message Authorization** | | |
| Established patients are allowed to email medical questions to Dr. Gandhi. I understand that incoming email is not encrypted and Dr. Gandhi will be responding to my email directly, in the same unencrypted manner that my email was sent. Neurology Associates of Central Jersey, LLC sends appointment reminders via email and/or cell phone text message. Neurology Associates of Central Jersey also sends patient satisfaction surveys via email no often than every 6 months. These messages are not encrypted and do not contain any personal medical information. By signing below, I agree to supply an email address AND/OR a cell phone number and receive these messages in order to confirm scheduled appointments. I will immediately notify Neurology Associates of Central Jersey if my contact information changes.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE OF PATIENT OR REPRESENATIVE DATE | | |
| **Prescription Benefits and Medication History** | | |
| I give consent for Neurology Associates of Central Jersey to download my prescription benefits and medication history information from my insurance company. | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF PATIENT OR REPRESENATIVE DATE DATE | | |

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| **Authorization for Release of Information** | | | | | |
| I hereby authorize Neurology Associates of Central Jersey, LLC to release any information necessary to my insurance company (ies), 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 case 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. | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF PATIENT OR REPRESENATIVE DATE DATE | | | | | |
| **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. | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE OF PATIENT OR REPRESENATIVE DATE | | | | | |
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| **Authorized Contacts** | | | | | |
| Many times family members will call and ask or give medically related information about the patient. So we may properly protect your privacy, please indicate yes, no, or n/a if you would like for us to share or discuss your private medical information with any of the following relatives/groups of people: | | | | | |
| **Yes** | **No** | **N/A** |  | **Name of Individual(s):** | |
|  |  |  | **Spouse:** |  |  |
|  |  |  | **Adult Child(ren):** |  |  |
|  |  |  | **Parent(s):** |  |  |
|  |  |  | **Other(s):** |  |  |