



Henry Tellez, MD
 Giridhar Chintalapudi, MD, FAASM
 Board-Certified in Neurology, Vascular Neurology, Neuromuscular and Sleep Medicine

295 Olmsted Blvd, Ste 12 Pinehurst, NC 28374
 101 Dennis Drive Sanford, NC 27330
 251 Keisler Dr., Ste 100 Cary, NC 27518

Phone: 910-235-0595

Fax: 910-235-0546

Patient Demographics

Name (Last, First, MI)			Today's Date		
Mailing Address		City		State	Zip
Home Phone () Preferred <input type="checkbox"/>		Work Phone () Preferred <input type="checkbox"/>		Cell Phone () Preferred <input type="checkbox"/>	
Social Security Number	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner <input type="checkbox"/> Other		
Preferred Language		Email Address			
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other _____		Ethnicity <input type="checkbox"/> Decline <input type="checkbox"/> Hispanic Origin <input type="checkbox"/> Not Hispanic Origin			

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		Policy #	Group#		
Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (If other than patient)		
Subscriber's Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber	Work Phone ()	
SECONDARY INSURANCE COMPANY		Policy #	Group#		
Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (If other than patient)		
Subscriber's Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber	Work Phone ()	

FINANCIALLY RESPONSIBLE PARTY

Is patient responsible party/Guarantor? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, fill out this section)				
Name	Address		City/State/Zip	Relationship to Patient
Employer		Email Address		Date of Birth
Home Phone () Preferred <input type="checkbox"/>	Work Phone () Preferred <input type="checkbox"/>	Cell Phone () Preferred <input type="checkbox"/>		

EMERGENCY CONTACT INFORMATION

Name			Relationship to Patient	
Home Phone () Preferred <input type="checkbox"/>	Work Phone () Preferred <input type="checkbox"/>	Cell Phone () Preferred <input type="checkbox"/>		

REFERRAL INFORMATION

Referring Physician's Name	Physician Phone/Fax ()
Address	

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician Name (<input type="checkbox"/> Check Here if same as referring physician)	Physician Ph#
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By signing below, I acknowledge the information I provided is correct to the best of my ability

Signature: _____

Date: _____

(910) 235-0595

(888) 688-5254

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Health History Questionnaire

PATIENT INFORMATION

Name (Last, First, MI)

Today's Date:

Referring Physician:

Primary Care Physician:

GENERAL HEALTH

1. Has your weight fluctuated much over the last year? Weight loss of 10+ pounds Weight gain of 10+ pounds
2. Do you smoke cigarettes? Yes No
 a) If yes, how many packs do you smoke per day?
 Less than ½ pack 1/2 pack 1pack 2 packs or more
3. How many alcoholic beverages do you have each week on average?
 None 1-7 drinks 8-14 drinks 15 or more drinks
4. How many days per week do you exercise 30 minutes or more?
 0 days 1-2 days 3-4 days 5-7 days

Have you ever had any of the following conditions?

<input type="checkbox"/> Brain Injury	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Swallowing problems	<input type="checkbox"/> Heart Valve Problems
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Allergies/Nasal Congestion/Sinusitis
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Down's Syndrome	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Heart Disease(Angina/Heart Attack)
<input type="checkbox"/> Panic Disorder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Allergies/Nasal Congestion/Sinusitis
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Sleep Apnea	

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Please list all other medical conditions you currently have: _____

Please list all medications and the dose you are currently taking:

Medication	Strength	How often?	Comments

In addition to prescribed medications, it is also important to include such things as:

- Eye drops Inhalers/Nebulizers Creams/Ointments Oxygen @____LPM Contraceptives
- Patches that contain medication Over-the-counter medication (example: Aspirin, antacids, vitamins, laxatives, etc).
- Dietary and herbal supplements (example: include Ginkgo Biloba, St. John's Wort, Green Tea, etc).

Drug Allergies: _____

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Office Policies & Fees

Financial Policy:

- Payments for services, including co- pays, are **DUE AT THE TIME SERVICES ARE RENDERED.**
- Your insurance is a contract between you and/or your insurance company. YOU are responsible for providing us with current and accurate health insurance information. If you do not provide the correct insurance information at the time of billing, your insurance company may deny the claim and YOU may be responsible for payment in full.
- You agree to have Medicare or other insurance companies make payments on your behalf directly to Sandhills Neurologists.
- You acknowledge and accept final responsibility for payment of all charges if your insurance company does not pay.
- Tests sent to outside laboratories may result in additional charges billed to you by the laboratory.
- You authorize release of medical information to Medicare or other insurance companies pertaining to your history, services rendered, or treatment given to you or your dependents for purposes of claims review.
- You are aware that Sandhills Neurologists, PA does not file Medicaid as a third party payor, if this condition applies to you.

Letters/Legal Paperwork:

- Letters, legal paperwork, disability forms and other miscellaneous forms will have applicable fees applied for their service preparation. Minimum charge is typically \$25.00 per letter or one page form. These fees depend on the quantity and depth of forms and documents that a patient requests us to prepare. Letters will be ready for pick up or for fax within 14 days of request. Payment may be required prior to pick-up, mailing, or faxing. If faxing or mailing to an address other than the patient's address of record, we must have a signed consent form. If mailing, additional mailing fees will apply.

Returned Checks:

- If a personal check is returned unpaid from the patient's bank, their account will be charged a returned check fee of \$25 for each check and their account may be placed on a "cash only" basis for one year.

Same Day Cancellations and No Show Fees:

- Much effort goes into staff scheduling and preparing for your visit. If you are unable to keep your appointment, please be considerate and notify us immediately. Failure to cancel within 24 hours of your scheduled appointment time deprives other patients from being seen in a timely manner.
- **"Physician Appointments"** - Missed appointments or appointments cancelled without 24 hour notice are subject to a \$50 fee. This fee will be collected at the second offense and appointments will not be re-scheduled until the fee has been paid. More than 2 missed appointment (or less than 24 hour notice) within 1 year will be subject to being permanently released from our practice.
- **"Diagnostic Testing Appointments"** - Diagnostic Testing appointments (such as Sleep Studies, EEG's, VNG's, etc) cancelled without giving **48 hour notice** are subject to a \$75 fee. This fee will be collected at the second offense and appointments will not be re-scheduled until the fee has been paid. More than 2 missed appointment (or less than 24 hour notice) within 1 year will be subject to being permanently released from our practice.

By my signature below, I acknowledge that I have read, understand and agree to the above.

Patient Signature

Date

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AGREEMENT AS TO RESOLUTION OF CONCERNS

“I”, “Patient/Guardian” shall be understood to mean _____.

“Physician” shall be understood to mean Henry Tellez, MD and/or Giridhar Chintalapudi, MD

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties (“ABMS”) board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the American Board of Psychiatry and Neurology.

In further consideration for this, Physician agrees to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician’s reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Henry Tellez, MD

Giridhar Chintalapudi, MD

Effective from Date of Treatment

Patient/Guardian Signature

Date of Signature

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