NEW PATIENT REGISTRATION

Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Full Name: _____ Date of Birth: _____ Sex:___

Address: _____City, State, Zip: _____

Home #:_____Cell #:_____ Social Security #_____

Marital Status: (select one) Single ○ Married ○ Divorce ○ Separated ○ Widowed ○

Race: _____ Ethnicity: _____ Language: _____ Email: _____

Employer Name: _____ Work #:_____

Emergency Contact: _____ Phone #:_____ Relation: _____

PHARMACY & Location: _____ Phone #:_____

Please list name and relation of individuals we could provide information to, for HIPPA release of information:

1. _____ 2. _____

PLEASE NOTE: IS IT PATIENT RESPONSIBILITY TO CONFIRM THAT WE ARE PARTICIAPTING PROVIDERS FOR YOUR PLAN
CALL THE PHONE NUMBER IN BACK OF YOUR CARD AND PROVIDE YOUR INSURANCE WITH OUR TAX ID: 264-73-3435
PROVIDERS: Dr. Qingxuan Wu Dr. Jennifer Sharron Dr. Nancy Burt

PRIMARY INSURANCE: _____

Name of Insured: _____ DOB: _____ SS#:_____

Member ID: _____ Group #:_____ In-network confirmed?_____

SECONDARY INSURANCE: _____

Name of Insured: _____ DOB: _____ SS#: _____

Member ID: _____ Group #:_____ In-network confirmed? _____

PLEASE LIST YOUR PRIMARY CARE PHYSICIAN and/or SPECIALISTS:

Name	Specialty	Phone number	Name	Specialty	Phone number

PLEASE LIST YOUR MEDICATIONS (if you already have printed list, hand it to reception):

Name	Form (pill, capsule, solution)	Strength	Frequency

HAVE YOU EVER HAD?

○ No known medical problems	○ Heart Valve Problems
○ Heart Attack	○ Stroke
○ COPD/Emphysema	○ Stomach/Gall Bladder Problems
○ Jaundice/ Hepatitis/ Other Liver Disorders	○ Ulcerative Colitis/ Crohn's Disease
○ Venereal Disease	○ Kidney Disease
○ Arthritis	○ Headaches
○ High Blood Pressure	○ Birth Defects/ Inherited Diseases
○ Seizure Disorder	○ Depression
○ Thyroid Problem	○ Diabetes
○ Eczema/ Psoriasis	○ Breast/ Prostate Problems
○ Anemia/ Blood Problems	○ Sexual Problems
○ Cancer If yes, Type:	○ Other:

HOSPITALIZATIONS:

Please list those serious illnesses that required hospitalization.

Month/Year	Illness

SURGICAL HISTORY:

Please list those surgeries that you have had in the past.

Month/Year	Surgery

SOCIAL HISTORY:

Do you now or have ever:
Smoked Cigarettes? Yes ○ No ○ If Yes, ___ Pkgs/Day #Yrs
Consumed Alcohol? Yes ○ No ○ If Yes, ___ Drinks/Wk
Consumed Coffee/Tea? Yes ○ No ○ If Yes, ___ Cups/Day
Used Street/Illegal Drugs? Yes ○ No ○ If Yes, type_____

ALLERGIES:

Allergic to:	Reaction:

FAMILY HISTORY:

Family Members	Status (Alive / Deceased)	If Deceased, Age at Death	Present Health or Cause of Death
Father			
Mothers			
Maternal Grandparents			
Paternal Grandparents			

The above information is true to the best of my knowledge. I authorize Alamo Neurology Consultants, PA or insurance company to release any information required to process my claims, which are payable to Alamo Neurology Consultants, PA. I also acknowledge receiving a copy and understanding the Notice of Privacy Practices. I understand that it is my responsibility to confirm I am being treated by an in-network provider and am financially responsible for any balance the insurance does not cover.

_____ _____

Patient (or Responsible Party) Signature Date

MEDICAL RECORDS RELEASE
AND AUTHORIZATION
FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

I authorize the custodian of my records to release the following information* (check all applicable):

- ☐ All records
- ☐ X-ray/radiology records
- ☐ Laboratory/pathology records
- ☐ Abstract/Summary

The information may be used for each of the following purposes:

- ☐ At my request
- ☐ For payment/insurance
- ☐ For my health care
- ☐ For employment purposes

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Please send the records listed above to:

Alamo Neurology Consultants, PA
11212 Hwy 151, Plaza 1, Ste 200
San Antonio, Texas 78251
Fax: 360-462-6496

This authorization shall expire no later than one year from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) Date

_____ _____

Printed name of patient representative Representative's authority to sign for patient, *(i.e parent guardian, power of attorney, executor)*

ANC Office Policies and Fees

Insurance: Please provide us with updated insurance information with a Photo ID. Copayments/deductibles are due at time of visit. If you have not met your deductible, we will collect $200 for the first visit and $125 for the follow up. Outstanding balances may result in rescheduling appointments.

In-Network Participation: It is patient responsibility to confirm the appointment doctor is an in-network provider with your plan, by calling the number in the back of your card and providing them with our Tax ID or NPI:

Alamo Neurology	Dr. Qingxuan Wu	Dr. Jennifer Sharron	Dr. Nancy Burt
TaxID: 264733435	NPI: 1548440340	PI: 1093033698	NPI: 1407851223

Patient Poral: We recommend the use of our patient portal for fast, secure messaging with our staff and providers. Ask our front desk for registration details.

Refills: Please plan ahead! ANC requires 48 hour notice for RX refills.

Medical Records: Patient records available upon request with ID. Transferring records by fax to another office requires a signed medical release from the receiving office. For paper copies, Printing fees may apply.

Third Party requests (law office, disability, employer) for Medical/Billing Records or Letter requests are subject to a $50.00 fee.

FMLA forms: At the provider's discretion for established patients, an appointment is required for FMLA documentation. Patient must bring in copy of forms to be filled.

NO call, NO show: Please allow us the courtesy of a 24 hour notice for rescheduling/cancelling appointments. We bill $50 for all appointments cancelled within 24 hours. You will not be rescheduled after 2 NO SHOWS.

Please sign below if you have read and understand our office policies and fees. Thank you.

_____ _____

Patient/ Responsible Party Signature Date