Charles P. Gennaula, M.D. Pushpa Kumari, M.D.

PATIENT INFORMATION FORM

PERSONAL INFORMATION (Please print clearly)

Patient's Name: ______________________ Age: ________ Birth date: ____________ Sex: ☐ M ☐ F

Address: ___________________________ ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

City: ________________ Zip: _____________ Social Security No: ___________________________

Home Phone: ______________________________ Cell Phone: ______________________________

Email: ___________________________ Insured's Employer/Phone #: ____________________________

Family Physician: ______________________________ ***Phone Number***: __________________________

Pharmacy Name: ______________________________ ***Phone Number***: __________________________

In case of emergency, contact ____

Relationship: ____________________ Phone No.: ______________

REFERRAL INFORMATION (Please tell us how you were referred to our practice)

Referring Physician: ____

Other Source: ____

AUTHORIZATION – PLEASE READ BEFORE SIGNING

To process my medical claims for payments, I ___________________________ hereby authorize CHARLES P. GENNAULA, M.D./PUSHPA KUMARI, M.D., or their authorized agents, to release copies of my medical records and/or provide information regarding my physical or mental condition and treatment rendered to my insurance carrier and/or any agent acting on the insurance carrier's behalf. I understand that these records and/or information may include psychiatric/psychotherapy, mental health, and/or drug and/or alcohol information or treatment records, and I authorize the release of such records and/or information to my insurance carrier and/or any agent acting on the insurance carrier's behalf.

I also authorize CHARLES P. GENNAULA, M.D./PUSHPA KUMARI, M.D. to release copies of my medical records to include the above-mentioned records and/or information to my primary care, family, or other treating physicians.

I understand that if this is a worker's compensation claim that the insurance carrier may employ a rehabilitation or consulting firm to handle my case. I authorize release of the above-mentioned records and/or information to the workmen's insurance and/or the rehabilitation or consulting firm.

I hereby assign to CHARLES P. GENNAULA, M.D./PUSHPA KUMARI, M.D. all payments for medical services rendered to myself and/or my dependents, and I understand and agree that any services not covered by my insurance company are my responsibility to pay.

Signature of Patient: ___________________________________ Date: ____________________

Office Use Only: VITALS BP__________ Pulse_______ HT_______ WT_________

PATIENT"S NAME______________________________ **BIRTHDATE**__________________

REASON FOR VISIT: ____

Medication Allergies (if none, check here ◯)

____

Environmental Allergies (dust, pollen, etc)

____

Medications **Please fill out or provide us with a list**

DRUG	DOSE	FREQUENCY

PAST MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO
Heart failure			Abdominal aortic aneurysm			Epilepsy		
Heart attack			Hepatitis			Headaches/Migraines		
Angina			Cirrhosis			Anemia		
Thoracic aneurysm			Kidney disease			HIV/AIDS		
Heart arrhythmia			Kidney stones			Bleeding disorder		
High blood pressure			Enlarged prostate			Cancer (type)		
High cholesterol			Arthritis			Anxiety		
High triglycerides			Diabetes mellitus			Depression		
Heart valve abnormality			Thyroid disorder			Other:		
DVT			Brain aneurysm					
COPD			Stroke					
Emphysema			TIA					
Asthma			Seizures					

PATIENT"S NAME____BIRTHDATE__________________

SURGICAL HISTORY

Type of Surgery	Date

Family History (Relatives) excluding self

DISEASE	NO	YES	RELATIVE	Mother's side	Father's side
ALZHEIMERS					
ANEURYSMS,brain,thoracic, abdominal aortic (circle)					
CANCER (type)					
DEMENTIA					
DIABETES					
HEART DISEASE					
HIGH BLOOD PRESSURE					
STROKE					
KIDNEY PROBLEM					
LIVER DISORDER					
LUNG PROBLEM					
MULTIPLE SCLEROSIS					
PARKINSON'S					
SEIZURES					
TREMORS					
Other					

Working:☐yes☐no Occupation____________________ If no:☐Disabled☐Unemployed☐Retired☐Homemaker

Marital Status: ☐single ☐married ☐separated/divorced ☐widowed. With whom do you live? ____________

Do you currently smoke? ☐ yes ☐no. How much per day? ____________________________

If no, did you ever smoke? ☐ yes ☐ no. How much? ________________ When did you stop? __________

Do you currently drink alcohol? ☐ yes☐ no. How much? ____________________________

If no, did you ever drink alcohol? ☐ yes ☐ no.How much? ________________ When did you stop? _______

Do you currently drink caffeinated beverages? ☐yes ☐ no coffee___soda___tea___How much? __________

Do you currently use recreational drugs? ☐ yes ☐ no. Which one(s)? _________________________

Do you exercise? yes _____ no _____ If yes, how often? _______________________________________

For Women Only

Menstrual Periods ☐Regular ☐Irregular ☐None Last Menses_______. Birth control pills? ☐Yes ☐ No

Is there a possibility of pregnancy ☐ Yes ☐ No Are you trying to get pregnant? ☐ Yes ☐ No

PATIENTS' NAME:______________________________ **DATE:** ____________________

Systems Review/Are you currently experiencing (please check ***none or applicable symptoms*** in each row)

Const: ☐none ☐fever ☐chills ☐malaise ☐fatigue ☐wt loss ☐wt gain ☐decreased appetite ☐night sweats

Eyes: ☐none ☐eye pain ☐vision loss ☐eyes red ☐dry eyes ☐itchy eyes ☐double vision ☐blurred vision ☐glasses ☐contacts

ENT: ☐none ☐earache ☐hearing loss ☐nosebleed ☐tooth pain ☐sore throat ☐hoarseness ☐ringing in ears ☐loss of smell ☐loss of taste ☐dentures

CV: ☐none ☐chest pain ☐palpitations ☐leg swelling ☐leg pain when walking ☐rapid heartbeat ☐slow heart beat

Resp: ☐none ☐short of breath ☐short of breath on exertion ☐Short of breath on lying ☐awakening short of breath ☐wheezing ☐cough

GI: ☐none ☐abdominal pain ☐nausea/vomit ☐constipation ☐diarrhea ☐heartburn ☐bloody stool ☐difficulty swallowing

GU: ☐none ☐incontinence ☐pelvic pain ☐painful urination ☐difficulties urinating ☐frequent urination ☐discharge ☐sexual dysfunction ☐Irregular periods ☐painful periods

Musc: ☐none ☐joint pain ☐joint swelling ☐joint stiffness ☐limb pain ☐limb swelling ☐Low back pain: ☐upper ☐middle ☐lower ☐muscle pain

Derm: ☐none ☐rash ☐skin lesion ☐itching

Neur: ☐none ☐confusion ☐seizures ☐dizziness ☐limb weakness ☐epilepsy ☐difficulty walking ☐Parkinson's ☐MS ☐headaches ☐dementia ☐tremors ☐migraines ☐Stroke ☐memory loss ☐vertigo ☐fainting ☐numbness ☐loss of consciousness

Psych: ☐none ☐anxiety ☐depression ☐hallucinations ☐sleep difficulties ☐suicidal thoughts ☐feelings stressed ☐personality change

Endo: ☐none ☐hot flashes ☐excessive thirst ☐generalized weakness ☐hot/cold intolerance

Heme: ☐none ☐easy bruising/bleeding ☐swollen glands

Other: ☐none ____

Consent to Use and Disclose Health Information And Acknowledgment and Receipt of Notice

This acknowledgment of Notice and Consent authorizes *Charles P. Gennaula M.D./Pushpa Kumari, M.D.* to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. The above named practice has a Notice of Privacy Practices. It describes how we may disclose and use your protected health information (PHI) and how you can access and exercise other rights concerning your PHI.

Right to Make Amendments. We reserve the right to change out Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of change.

You may obtain a revised notice by submitting a written request to our Privacy Officer at the address listed below.

Charles P. Gennaula, M.D.
Pushpa Kumari, M.D.

100 Peasant Village Lane
Belle Vernon, PA 15012

Attn: Privacy Officer
Phone: 724 929 7800
Fax: 7249293229

You should review our current notice prior to signing this Acknowledgment and Consent.

I have received the Notice of Privacy Practices for *Charles P. Gennaula, M.D./Pushpa Kumari, M.D.* This practice is authorized to use and disclose health information about ________________________ (print patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

____________________________ ________________

Signature of Patient or Representative Date

____

Relationship to Patient

Authorization to Disclose Specific Protected Health Information

Patient Name:__________________ Date:____________________

By signing this Authorization, I hereby direct the disclosure by *Charles P. Gennaula, M.D./Pushpa Kumari, M.D.*, and other authorized staff, of certain medical information pertaining to my health care with regards to **Lab, MRI, X-Ray, EMG, or other testing as well as routine office care** to the following people.

Name______________________ Relationship________________________ Phone________________________

Name______________________ Relationship________________________ Phone________________________

Name______________________ Relationship________________________ Phone________________________

I understand that I have the right to revoke this Authorization at any time except to the extent that *Charles P. Gennaula, M.D./Pushpa Kumari, M.D.* has already acted in reliance to the Authorization. To revoke this Authorization, I must do so in writing and have it sent to the office at 100 Peasant Village Lane, Suite 100, Belle Vernon, PA 15012.

I acknowledge that I have read the provisions in the Authorization and I understand and agree to it's terms.

Patient Signature:__________________________________ Date________________________________

This Authorization expires on discontinuation of treatment at our office unless otherwise stated by the patient.

CHARLES P. GENNAULA, M.D.
Specializing in Neurology

Charles P. Gennaula, M.D.
Pushpa Kumari, M.D.

100 Peasant Village Lane
Belle Vernon, PA 15012
724-929-7800
Fax 724-929-3229

JMA Building, Suite 120
1200 Brooks Lane
Jefferson Hills, PA 15025
412-469-7202

OFFICE FINANCIAL and CANCELLATION POLICY
Effective 1-1-2017

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is our payment/financial policy.

CO-PAYMENTS MUST BE PAID AT THE TIME OF SERVICE. NO EXCEPTIONS!

Payment is required at the time of service. This includes co-payments, co-insurances, deductibles, or private pay. There will be NO EXCEPTIONS for any reason unless arrangements have been made prior to appointment.
We accept cash, check, or credit cards. There will be a $25 service charge for all returned checks and your account will be placed on a cash only basis, in which we will accept payments only by cash or credit card for any future services.
Any charges/balances not covered by your insurance are your responsibility and must be paid prior to any future scheduled appointment.

In the best interest of all our patients, we must maintain a cancellation and no show policy. We require a 24 hour notice for all cancelled appointments. After 3 no show appointments (missed appointments without cancellation), we may ask you to seek another neurologist. You will be sent a letter in the mail.

By signing below, I have read, understand and had the ability to ask questions regarding the information as written above.

_______________________________ Patient Signature

_______________________________ Date