Peter A. Tarbox M.D., PA

Neurology Consultants of San Antonio

CERTIFIED BY THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

5441 Babcock Rd Ste 301 San Antonio, TX 78240

Office: (210) 641-1394 Fax: (210) 561-2846

SSN: Phone: ( )	Cell: ( ) Work: ( )
Last Name:	Date of Birth: Female Male
First Name: Middle Initial	Pharmacy Name:
Address:	Pharmacy Address:
City:	Pharmacy Phone Number:
State: Zip:	Single Married Divorced Widowed
Your E-MAIL Address:	**Best Way to reach you?** Phone: Home /Work /Cell /E-mail (**please indicate** by circling one, or more, above)
Name of Primary Insurance:	**Name of Secondary Insurance:**
ID #: Group #:	ID #: Group #:
Policy Holder:	Policy Holder:
Relationship: Self Spouse Child	Relationship: Self Spouse Child
Insured's SS#: Insured's DOB:	Insured's SS#: Insured's DOB:
Insured's Address:	Insured's Address:
City, State & Zip:	City, State & Zip:

IN CASE OF AN EMERGENCY CONTACT: (e.g. a relative, that is not living with you, or a friend)

Name:

Address: City: State:

Phone: ( ) Cell: ( ) Relation:

YOUR PRIMARY CARE PHYSICIAN: _____ Phone: (___)_____

THE DOCTOR WHO REFERRED YOU: _____ Phone: (___)_____

AGREEMENTS OF BENEFITS:

I HEREBY ASSIGN ALL MEDICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS, TO PETER A. TARBOX M.D., PA. I UNDERSTAND THAT I AM RESPONSIBLE FOR SCHEDULING WITH A PARTICIPATING PHYSICIAN AND TO FOLLOW UP ON ANY DISCREPANCY IN COVERAGE WITH MY INSURANCE PLAN. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE PETER A. TARBOX M.D., PA TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Signed: _____ Date: _____

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Date: _____

Name: _____ **Age**: _____ **Male** or **Female** **Right handed** or **Left handed**

Current Condition: What brings you to our office today? _____
How long have you had this condition? _____
List any previous test or procedures performed for this problem: _____

_____

(Please print ALL MEDS, or provide a list)

Medication/Dosage	**Reason for Medication**	**Medication/Dosage**	**Reason for Medication**

Do you have any other medical conditions not listed above? _____

_____

List **ALL** Surgeries & Hospitalizations - Please use the other side of this paper, if needed.
1. _____ **Where**? _____ **What year**? _____
2. _____ **Where**? _____ **What year**? _____
3. _____ **Where**? _____ **What year**? _____

List any **FAMILY** medical history: _____

Are you **ALLERGIC** to any **MEDICATIONS? NO / YES**, if **YES** please list. _____

Do you **SMOKE? YES / NO** Are you **MARRIED**? **YES / NO** How many children? _____
How much? _____ Do you drink **ALCOHOL**? **YES / NO** How Much? _____

If desired, which physicians would you like your medical records to be sent to besides the referring physician?
_____

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Date: _____

Name: _____

REVIEW OF SYSTEMS: Review the List below and **CHECK** any problem that you currently, or in the recent past, have experienced.

__Anxiety
__Back pain
__Balance difficulties
__Blood in sputum
__Blood in urine
__Breast discharge
__Change in Facial appearance
__Change in mole appearance
__Change in speech
__Chest pains
__Chills
__Chronic fatigue
__Cough
__Depression
__Difficulty chewing
__Difficulty starting urine stream
__Dizziness
__Double- vision
__Easy bruising
__Falling
__Fever
__Gait or Walking difficulties
__Headaches
__Hearing-Ringing in ears
__Heart Palpitations
__Hemorrhoids
__Hives/Rash
__Inappropriate or excessive crying / laughing
__Increased urinary frequency
__Insomnia
__Itchy skin
__Joint pain
__Joint swelling
__Loss of appetite
__Loss of balance
__Loss of hair
__Loss of hearing
__Loss of sight
__Lumps in breast
__Memory loss
__Mood swings
__Muscle cramps
__Nausea/Vomiting
__Neck Pain
__Nervousness
__Night Sweats
__Numbness
__Pain in arms and legs
__Passing out
__Passing stones in urine
__Pus in urine
__Sense of smell
__Shortness of breath
__Sleep disturbance
__Stomach ulcers
__ Swallowing
__ Swelling of hands/ankles
__ Tingling
__ Vertigo
__Weakness
__Weight gain
__Weight loss
__Wheezing

FEMALES:
_____Last menstrual cycle
_____Last pelvic exam
__Irregular periods
__Excessive bleeding
__Painful periods

MALES:
__Difficulty urinating
__Difficulty with ejaculation
__Difficulty with erection
__Discharge from penis

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Patient Consent for the Disclosure of Information

I have read the **NOTICE OF PRIVACY PRACTICES** and have had the opportunity to ask questions. I understand that this consent applies to me as the patient, or to the patient(s) indicated below for whom I am the parent, guardian, or legal representative.

_____ _____

_____ _____

I understand that by signing this form I consent to the following:

***Sharing information for purposes of treatment*:** You will share information with all members of a treatment team, both within this office and with other providers [personal and institutional] in order to provide quality care and the educational/wellness programs specified in my insurance plan;

Sharing of Information for Purposes of Payment: You will share all necessary information with Insurer[s], payor[s], governmental entities [such as Medicare, Medicaid, etc.] and their representatives [including, but not limited to, benefit determination and utilization review] as well as your representatives involved in the billing process [including, but not limited to claims representatives, data warehouses, billing companies].

Sharing of Information for Purposes of Operations*:* You will share all information necessary for ingoing operations of this office, including [but not limited to] the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

Sharing of Information with Assignment to Others*:* You will share information with the following individuals whom I have designated to function on my behalf, as needed:

First & Last Name	Relationship	Phone Number

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosure given in reliance on this prior consent will be permissible**.**

_____ _____
Patient's Name Date

_____ _____
Patient, Guardian, or Legal Representative's Signature Date

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AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient (Please Print) _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____ Phone _____

Maiden name or other name used for records _____ Practice Use: MedRec# _____

I hereby authorize: (Please Print)
NAME: _____
ADDRESS: _____
_____
PHONE #: _____
FAX #: _____

To release to: (Please Print)
NAME: _____
ADDRESS: _____
_____
PHONE #: _____
FAX #: _____

The following information from my records:

- ❑ Complete Health Record(s) [1]
- ❑ Operative Report [2]
- ❑ Progress Notes [3]
- ❑ Other (Please Specify) [4]
- ❑ History & Physical [5]
- ❑ Laboratory Report [6]
- ❑ Discharge Summary [7]
- ❑ Radiology Reports/Films [8]
- ❑ All Nuclear Medicine Reports [9]
- ❑ Pathology Reports [10]
- ❑ Financial Records [11]

I ❑ do (check applicable box) authorize this information to be faxed. If yes, fax number: _____

Covering the period from _____ to _____

_____ (Initial) I understand that this authorization will include information relating to:

- ✓ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
- ✓ Psychiatric care
- ✓ Treatment for alcohol and/or drug abuse
- ✓ Genetic Testing

If any, except as specifically stated here: _____

This information is to be disclosed for the purpose of _____

The date, extent or condition upon which this authorization expires is _ _____ not to exceed 24 months (except for research purposes, state "**NONE**" for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other than **NEUROLOGY CONSULTANTS OF SAN ANTONIO** and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). I expressly request release of all records maintained by **NEUROLOGY CONSULTANTS OF SAN ANTONIO** concerning me, including incorporated records. I acknowledge that **NEUROLOGY CONSULTANTS OF SAN ANTONIO** has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release **NEUROLOGY CONSULTANTS OF SAN ANTONIO** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. **NEUROLOGY CONSULTANTS OF SAN ANTONIO** is not responsible for completeness, legibility, or omissions caused by the copying of any medical records from another institution.

_____ _____
Signature of patient or patient's representative **Date**

Printed name of patient's representative _____ Relationship to patient _____

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CONSENT TO EXAMINATIONS AND DIAGNOSTIC PROCEDURES

I, _____ do hereby authorize Peter A.Tarbox, M.D. a medical doctor to perform upon me, examination and diagnostic procedures arising from any current or presently unforeseen condition(s) which Peter A Tarbox, M.D. may consider necessary or advisable in the course of my healthcare.

I understand and agree that Peter A. Tarbox, M.D., PA has the right to refuse to accept me as a patient at any time before treatment begins. The taking of history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that Peter A. Tarbox, M.D., PA can determine whether to accept me as a patient.

_____ _____
Printed Name of Patient Printed Name of Witness

_____ _____
Signature of Patient Date Signature of Witness Date

Patient Consent: I hereby authorize **Peter A. Tarbox, M.D., PA** and his qualified staff to administer procedures and treatment, as they deem necessary.

_____ _____
Patient Signature Date