

Comprehensive Neurology Clinic

Refaat El-Said, MD

Dina Dahan, MD

Phone: 407-208-0708

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Dear New Patient,

Welcome to our office. We now have two locations. Please make note of your appointment day, time, and location.

Appointment _____ (date) at _____ (time)

Location: () 10967 Lake Underhill Road, Suite 148, Orlando, FL 32825

 () 3232 Hillsdale Lane, Kissimmee, FL 34741

Please bring the following items with you to your appointment.

Patient Registration Form – completed

Patient History Form – completed

Insurance Card

Driver's License

Medical records

Physician referral forms – if required by insurance

MRI and CT reports – if any

MRI and CT films or CDs – if any

List of your current medications

If you cannot keep this appointment, please provide at least 48 hours notice to our office. Otherwise, missed appointments may incur a \$50 fee. Thank you for your cooperation.

Sincerely,

The staff of Comprehensive Neurology Clinic

www.CNC-Neurology.com

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Patient Registration Form

Today's Date: _____ Date of Birth: _____

Patient's Name: _____ Age: _____ () Male
() Female

Address: _____ City: _____ State:
____ Zip: _____

Social Security #: _____ Driver's License #: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Marital Status: _____ E-mail Address: _____

Employer: _____ Phone: _____ Address: _____

Emergency Contact 1: _____ Relationship: _____ Phone: _____

Emergency Contact 2: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State:
____ Zip: _____

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State:
____ Zip: _____

Patient's Primary Insurance

Name of Insurance: _____

Policy #/ID #: _____ Group #: _____

Policyholder's Name: _____ Date of Birth: _____

Social Security #: _____

Relationship to patient:

Patient's Secondary Insurance

Name of Insurance:

Policy #/ID #: _____

Group #:

Policyholder's Name: _____

Date of Birth:

Social Security #: _____

Relationship to patient:

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Patient History Form

Name: _____ Date of Birth: _____

Drug Allergies: ()Yes ()No List: _____

Medications currently being used (including non-prescription drugs taken regularly):

Name of Drug	Dose	How often

Have you had any hospitalizations or surgeries (not including pregnancies)? ()Yes ()No If yes, list below.

Date	Diagnosis	Treatment	Doctor	Hospital

Personal and Family Medical History:

Medical Condition	Self	Family	Relationship	Maternal or Paternal?
Heart Problems	()Yes ()No	()Yes ()No		()M ()P
High Blood Pressure	()Yes ()No	()Yes ()No		()M ()P
Cancer	()Yes ()No	()Yes ()No		()M ()P
Diabetes	()Yes ()No	()Yes ()No		()M ()P
Stroke	()Yes ()No	()Yes ()No		()M ()P
Depression or Suicide	()Yes ()No	()Yes ()No		()M ()P
Asthma	()Yes ()No	()Yes ()No		()M ()P
Sleep Problems	()Yes ()No	()Yes ()No		()M ()P
Other:	()Yes ()No	()Yes ()No		()M ()P

Marital Status: _____ Number of children: _____

I drink alcoholic beverages _____ times per day, _____ times per week.

I smoke _____ cigarettes (or pipes, or cigars) per day.

Have you ever used recreational or street drugs? ()Yes ()No What & When: _____

Is your condition related to a work accident or injury? ()Yes ()No

Is your condition related to an automobile accident? ()Yes ()No

Have you seen an attorney regarding your condition? ()Yes ()No

Have you seen any other neurologist? ()Yes ()No If yes, who? _____

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Medical Records Release & Insurance Assignment



Name of Patient: _____ Date of Birth: _____

I authorize the release of medical records to Comprehensive Neurology Clinic from other healthcare providers for the purpose of diagnosis, treatment, and continued care. Further, I release all applicable healthcare providers from all responsibility and/or liability that may arise from this authorization.

Initials: _____

I authorize Comprehensive Neurology Clinic to release any medical information and records concerning diagnosis and treatment to any third party, insurance company, or government agency for the purpose of processing claims and payment.

Initials: _____

I authorize Comprehensive Neurology Clinic to release medical records to healthcare providers involved in continuing care and treatment.

Initials: _____

I authorize payment of insurance benefits directly to Comprehensive Neurology Clinic for services rendered and release any medical information necessary to process claims. I am responsible for co-payments, non-covered services, and deductible amounts. I am responsible to supply Comprehensive Neurology Clinic with the most current insurance information and any changes to insurance coverage prior to services rendered. I am responsible to obtain a referral or authorization from the Primary Care Physician, if required by insurance.

Initials: _____

I permit a copy of these authorizations and assignments to be used in place of this original form.

Initials: _____

I release Comprehensive Neurology Clinic from all responsibility and/or liability that may arise from this authorization.

Initials: _____

This release and assignment remains in effect for one (1) year, or until revoked in writing by the patient or responsible party.

Initials: _____

Signature of Patient or Responsible Party: _____

Printed Name: _____ Date: _____

Relationship to Patient: _____