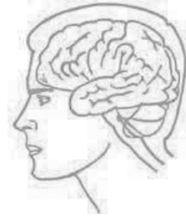
Comprehensive Neurology Clinic



Refaat El-Said, MD
Dina Dahan, MD
Phone: 407-208-0708
Fax: 407-208-0709

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

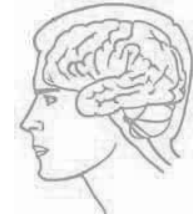
If you cannot keep this appointment, please provide at least 48 hours notice to our office. Otherwise, missed appointments may incur a $50 fee. Thank you for your cooperation.

Sincerely,

The staff of Comprehensive Neurology Clinic
www.CNC-Neurology.com

Comprehensive Neurology Clinic

Refaat El-Said, MD & Dina Dahan, MD



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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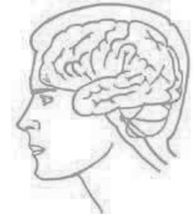


Patient History Form

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

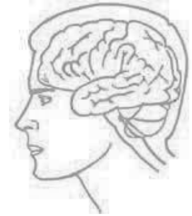
Marital Status: ___________________________________ Number of children: ____________________

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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Refaat El-Said, MD & Dina Dahan, MD

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: ____________

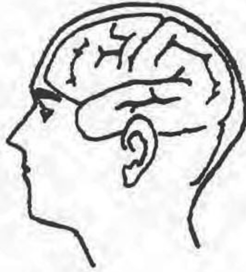
This release and assignment remains in effect for one (1) year, or until revoked in writing by the patient or responsible party.

Initials: ____________

Signature of Patient or Responsible Party: ____

Printed Name: ____ Date: __________________________

Relationship to Patient: ______________________________________



Comprehensive Neurology Clinic

Refaat El-Said,M.D.
Board Certified in Neurology
and Clinical Neurophysiology

Dina Dahan, M.D.
Board Certified in Pediatrics
Board Certified in Child Neurology

Patient Release of Medical Records Form

Patient's Name: ____________________ request and give my permission to release my Medical Records for the time period of_________________ to _________________ to the following Medical Clinic:

Comprehensive Neurology Clinic
10967 Lake Underhill Road, Ste 148
Orlando, FL 32825
(407) 208-0708 office (407) 208-0709 fax

The Medical Records as listed above are to be released from/TO:

Name:____

Address:_______________________________________

City_____________________State__________zip_____

Phone Number:__________________________________

Fax Number:___________________________________

Comments______________________________________
____

This authorization includes consent to Fax the above record, if necessary.

____
Print Name

____
Date DOB:

Signed: _____________________________