Surjit K. Kahlon, MD

Adult & Pediatric Neurology
630 North 13th Ave., Suite B, Upland, CA 91786

Pediatric Intake Forms

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH:_____

REASON YOU ARE BEING SEEN:_____
_____

REFERRING PHYSICIAN:_____
ADDRESS: _____
CITY, ZIP CODE: _____
PHONE NUMBER(_____)_____

BIRTH HISTORY
Mother's age at conception:_____
Number of prior pregnancies: _____
Duration of pregnancy:_____
Complications: _____
_____
Length of labor:_____
Induced yes no Anesthesia yes no
Forceps yes no Type:_____
Complications of delivery:_____
_____
_____
Birth weight :_____ lbs. _____ oz.
Breathed immediately? yes no
Required oxygen? yes no
How long?_____
Discharge from hospital_____days
Did the baby suck well in Newborn Nursery?
yes no

GROWTH AND DEVELOPMENT-Age of onset
Rolled from back to front _____
Sat without support_____
Pulled up_____
Walked_____
First meaningful words_____
Phrases_____
Sentences_____
Ride 2 wheel bike without training wheels
_____
Present grade_____
School performance - Satisfactory or not. If not
Explain_____
_____

ILLESSES
Any serious medical problems requiring hospitalization?
Describe:_____
_____ age_____
_____ age_____
_____ age_____
Any operation? Describe _____
_____ age_____
_____ age_____
Unconsciousness? yes no
How long: _____

FAMILY HISTORY

Mother _____ age_____
Health_____
Years of schooling_____
Father_____ age_____
Health_____
Years of schooling_____
Mother and father living together?_____
Siblings name_____ age_____
Health_____ full sibling yes no
School performance_____
_____
Siblings name_____ age_____
Health_____ full sibling yes no
School performance_____
_____

Siblings name_____ age_____
Health_____ full sibling yes no
School performance_____
_____
Siblings name_____ age_____
Health_____ full sibling yes no
School performance_____
_____
Siblings name_____ age_____
Health_____ full sibling yes no
School performance_____
_____

FAMILY DISORDERS:

			Relationship
Epilepsy	yes	no	_____
Convulsions	yes	no	_____
Stroke	yes	no	_____
SIDS	yes	no	_____
Brain Tumor	yes	no	_____
Eye problems	yes	no	_____
Headaches	yes	no	_____
Migraines	yes	no	_____
Mental illness	yes	no	_____
Retardation	yes	no	_____
Cerebral Palsy	yes	no	_____
Muscle disease	yes	no	_____

13 and older: Smoking Status

Current every day smoker
Current some day smoker
Non-smoker
Former
Smoker-Unknown
Unknown
Never Smoked

ROS

Pediatric Review of Systems for ages Birth to 17

Print CHILD's Name:	**Birth Date:**
DIRECTIONS: Please circle any of the items listed below in which your child has recently or is currently experiencing.	

[ ] **GENERAL**: NONE, unusual level of activity, appetite changes, abnormal sleep, abnormal growth and development, speech and language impairment, fevers / chills.

[ ] **Head, Ears, Eyes, Nose, Throat**: NONE, frequent headaches, hearing problems, vision impairment, stuffy nose or itchy/watery eyes, difficulty swallowing.

[ ] **Cardiovascular: (Heart, Blood vessel)** NONE, chest pains, palpitations or irregular heart beat.

[ ] **Respiratory:(Lungs)** NONE, problems with coughing, problems with wheezing, shortness of breath.

[ ] **GI:(Stomach/Digestion)** NONE, diarrhea, constipation, abdominal pain, vomiting.

[ ] **GU:(Urological/Bladder/Kidneys)** NONE, loss of bladder control (incontinence), loss of bowel control, concerns about child's sexual development.

[ ] **Musculoskeletal:(Bones/Joints/Muscles)** NONE, joint pain, muscle pain, immobility or loss of function, head/neck/ back pain, pain when walking, rheumatoid arthritis, lupus, chronic fatigue syndrome, fibromyalgia

[ ] **Integumentary (SKIN):** NONE, skin rashes, acne, abnormal birthmark.

[ ] **Neurological:** NONE, Headaches, Migraines, Seizures, Fainting, Lightheadedness, Dizziness upon standing, Vertigo, Short term memory problems, Long term memory problems, Head Injury, Confusion/disorientation, Delusions, Change in personality, Facial weakness/numbness, Drooling, Involuntary movements, Handwriting change, Trouble with coordination, Difficulty walking, Tremors, Balance problems, Change in gait

[ ] **Psychiatric**: NONE , uncooperative or defiant, trouble getting along with others, anxiety, depression, mood swings, psychiatric hospitalizations.

[ ] **Endocrine:(Glands)** NONE, bruises easily or bleeding, difficulty with hot or cold environments, excessive thirst, excessive urination.

[ ] **Smoking Status:** Non-smoker, Never smoked, Former smoker, Smoker

NAME: _____

Pharmacy Name: _____ **Phone:** ( ) _____

Address: _____

Prior medications used for present problem:

_____ _____

ALLERGIES: _____

Medication	Dose	How many times a day?	Date Medication started	Prescribing doctor	Reason for Medication (Ex: Diabetes)	Any Side Effects?
Over The Counter Medications/ Diet Product/ Herbal Product						

THE NEUROLOGY GROUP
ADULT & PEDIATRIC NEUROLOGY

2895 N. TOWNE AVENUE, POMONA, CA 91767 (909) 267-7495 (909) 982-2719
630 N.13th AVE., SUITE B UPLAND, CA 91786 FAX (909) 946-9931 (909)625-8753

DEMOGRAPHIC SHEET

Date: _____

Patient Name _____ **DOB:** _____

Race/ Ethnicity _____

Current Mailing Address: _____

Primary Phone Number: _____

Secondary Phone Number: _____

Primary E-mail Address: _____

Primary/Referring Providers Name: _____

Have you ever smoked before: YES / NO

If yes how long ago? _____

Frequency: 1-5 **6-10**
Half a pack a day **1 pack a day**

Emergency Contact:

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Pharmacy Information:

Name: _____

Address: _____

City & Zip code: _____

Phone number: _____

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Acknowledgement of Receipt of Notice of Privacy Practices
PATIENT INFORMATION CONSENT FORM

I have read and fully understand Notice of Information Practices. I understand that Surjit K. Kahlon, M.D. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to my treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that Surjit K. Kahlon, M.D. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____
Patient Name Date

_____ _____ _____ _____
Patient or Guardian Signature Date updated Patient or Guardian Signature Date update

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____ Name: _____ Relationship: _____

Name:_____ Relationship:_____ Name:_____ Relationship: _____

_____
Patient or guardian signature

INSURANCE/PAYMENT AUTHORIZATION FORM

I understand that charges for medical services in this office are my responsibility. Appropriate efforts will be made by this office to bill my insurance, workman's comp, etc. if applicable, however I understand that co-pays, deductibles, and ultimately the total amount of my bill is my responsibility and I will be expected to settle my account in a timely manner. I authorize the release of medical information to process claims. I authorize payments under my insurance programs to be made directly to Surjit K. Kahlon, M.D. for any services furnished to me. I also designate that any settlement from litigation first be applied to my medical bills from this office. This authorization also permits the release of information by HCFA (its intermediates or carriers) on any UNASSIGNED Medicare claims to the above. I further permit copies of this authorization to be used in place of the original.

_____ ***Date:*** _____

Patient (or responsible party) signature

MEMBER INSURANCE WAIVER

Dear ALL INSURED PATIENTS: DATE:_____

If verification of coverage for your health plan benefits cannot be made at this time, services will be provided to you at this visit; however, in the event your coverage is not effective, you will be held responsible for payment. If in the event your health plan denies payment for services rendered, you, the patient will be held financially responsible. We will make every effort to bill your health plan before we bill the patient.

Patient Name: _____ Social Security No. _____
Subscriber's Name: _____ Social Security No._____
Address: _____City_____ST_____Zip code_____
Subscriber's Phone No. (day) (_____)_____ (Evening)(_____)_____
Insurance ID No. _____ Date of Birth (subscriber) _____
Subscriber's Employer _____Phone No.(____)_____

Patient or Guardian's Signature _____Date signed _____
Patient or Guardian's printed name _____

APPOINTMENT & CANCELLATION POLICY

Please read and sign at the bottom

BY APPOINTMENT ONLY

Desai Neurology Group sees patients by appointment only. We make every effort to provide prompt medical care to all of our patients. If you arrive in our clinic as a *walk-in*, please understand that you will be asked to schedule an appointment for a different time. It is your responsibility to know when your next appointment is scheduled. You may request a reminder call as a courtesy; however, the responsibility of remembering your appointment is still yours regardless of whether or not we are able to reach you by phone.

LATE ARRIVALS

We make every effort to maintain appointment time commitments and we request that you extend the same courtesy to us. If you are running late, please call our clinic to reschedule. We understand that special circumstances can arise, which may cause you to run a few minutes behind. On occasion we are able to work-in late arrivals into the schedule; however, this is at the discretion of our front office staff. If you are more than 15 minutes late for an appointment, to help avoid delays in treatment and extensive waiting times, we may ask you to reschedule.

MISSED APPOINTMENTS (*NO SHOWS*)

The staff at Desai Neurology Group respects your time and we ask for the same courtesy. Missed appointments (*no shows*) affect our ability to provide timely attention to our patients. When a patient does not *show up* for their appointment, another patient loses an opportunity to be seen. If you are unable to make your appointment, we respectfully ask that you notify our clinic at least 24 hours in advance. Failure to cancel an appointment that you do not attend will be considered a missed appointment or *no show and* you will be charged $75 *no show* fee.

Protocol for *No Shows*:

If you fail to attend your appointment you will be charged a $75 *no show* fee. In addition, a course of action will be determined based on the clinic team's review of your case and individual situation. You are directly responsible for payment of the *no show* fee on or before your next appointment. The *no show* fee cannot be billed to your insurance company.

PLAN ACCORDINGLY

Please remember that it is your responsibility to monitor your medication usage and to plan for your monthly follow up visits if you need refills. Desai Neurology Group does not consider it an emergency if you run out of medication as a result of a cancelled or missed (*no showed*) follow up visit. If you arrive at the clinic without an appointment, expecting to be seen for a refill, an appointment will be scheduled for you and you will be asked to return at that time. It is against our policy to *call-in* a prescription to a pharmacy for prescribed medications if the request is not submitted within our 72 hour turnaround time under any circumstance. Please plan your monthly follow up visits accordingly, taking holidays, weekends, and other non-clinic days into consideration.

RETURNING AFTER DISCONTINUING SERVICES

If you are an established patient and have not seen us for twelve (12) consecutive months, you will be required to complete a comprehensive screening and orientation session as part of our new patient evaluation (full intake).

THANK YOU FOR YOUR PATIENCE

We value you as our patient and know your time is valuable and we are always looking for ways to improve our ability to manage the rapid growth of new patients. It may seem that you are waiting a long time or that patients who arrive after you are being taken first. Please understand that waiting patients may not necessarily get *called back* in the order they arrive at our clinic. This is due to simultaneous appointment schedules, which are specific to multiple doctors in our clinic

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PATIENT NAME: _____

SIGNATURE: _____ **DATE:** _____

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COPY FOR PATIENT TO KEEP

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

SURJIT K. KAHLON, M.D. INC. LEGAL DUTY

Surjit K. Kahlon, M.D. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Surjit K. Kahlon, M.D. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Surjit K. Kahlon, M.D. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Surjit K. Kahlon, M.D. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, Surjit K. Kahlon, M.D. policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Surjit K. Kahlon, M.D. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Surjit K. Kahlon, M.D. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Surjit K. Kahlon, M.D. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Surjit K. Kahlon, M.D. health information practices or if you have a complaint, please contact the following person:

Privacy Officer
Surjit K. Kahlon, M.D. Inc.
2895 N. Towne Ave., Pomona, Ca. 91767
Phone: 909-982-2719 909-267-7495