Sheri E. Bisby,MD

804 CR 466 Lady Lake FL 32159

Phone (352) 750-6387 Fax (352) 753-7141

ncexcellence@outlook.com

Thank you for selecting Dr. Sheri
We look forward to you joining our family.

Please complete this New Patient Packet and return with copy of insurance cards ***7 days prior to the first appointment***.

- Please provide to us the following records:
  - Office Notes
  - Labs-Radiology MRI, Echo, EKG, EEG, etc
  - Or provide contact information so we can request them from the appropriate facilities or physicians provided by you

- It is very important that you have the paperwork completed in its entirety. This will ensure that you will have a thorough new patient visit

- You may mail, fax, email or return the packet to the office at the address above Monday - Thursday 8am-5pm

How did you hear about us: Newspaper_______,Radio________
Doctor referal_____, Magazine______, Website______, Phone book_____
Internet_____, Friend/Family_____, Other (please specify)____________

Name _________________________ DOB __/__/___ Age _____

Home Phone (___)_____-_________ Cell (___)____-_______

Email __________________________________ SS# ____/___/____

Mandatory **Mandatory**

Address ____

Power of Attorney{P.O.A.}Name ________________ (Please provide POA documentation if applicable) POA Phone (___)_____-__________

Emergency Contact ____________________ Relationship _______________

Phone(___)____-_______ How did you hear about us _________________

Primary Doctor ___________________ Referring Doctor _________________

Right Handed/ Left handed Preferred Language __________

Race _________ M/F Hispanic or Latino/Non Hispanic or Latino

Reason for visit ____________________ Symptoms _______________________

Episode Length _______________________

Initial Onset of symptoms ___/___/___ Started Fast/Slow

Improves With ______________________ Worsens With ___________________

Failed Treatments ____

Effective Treatments ____

Insurance Information
(Please give your insurance card and photo ID to receptionist)

Person Financially Responsible______________________ DOB ___/___/___

Phone (___)____-_______ Address ___________________________________

Employer ________________________ Occupation ______________________

Work Phone (___)____-_______ Work Address _________________________

Primary Insurance _____________Policy# _______________ Group# _____

Subscriber ________________________ DOB ___/___/____

Relationship to Patient ________________________ Copay _________

Subscriber Social Security Number ______-______-________

Secondary Insurance ____________Policy# _______________ Group#

______ Subscriber ____________________________ DOB _____/_____/

______ Relationship to Patient ___________________________ Copay

_________ Subscriber Social Security Number ______-______-_______

Patient Note: Starting May 1, 2017 there will be a $75.00 cancellation fee if you cancel your appointment with 24 hours of the appointment time.

Patient Initials:____________

Are you involved in any motor vehicle accident? Y / N

If so please provide the following documentation it is MANDATORY BEFORE you are seen/ or treated by Dr. Bisby:

1. Name, address and phone number of the patient's vehicle insurance company.
2. Insurance claim adjuster's name and phone number.
3. Vehicle insurance policy number.
4. Date of injury (very important)
5. Name, address and phone number of patient's attorney for the MVA, and contact personnel at the attorney office

Billing process for patient involved in an MVA.

1. Patients are responsible for all Copay and deductibles to the physician.
2. Billing is then sent to the Patient's vehicle insurance for payment. Vehicle insurance will either pay the billing or deny billing.
3. Billing, if not paid by the patient's vehicle insurance, will be billed to the patient's health insurance. Patient's health insurance will then either pay the billing or deny the billing
4. Billing, if not paid by the patient's health insurance, will then go to the patient attorney for reconciliation

Any unpaid billing or fees accrued by Dr. Bisby will become the responsibility of the patient for payment.

Patient Signature _________________________________ Date __________

(Mandatory)

Type	Name	Phone	Reason
Primary Physician			
Neurologist			
Rheumatologist			
Ophthalmologist			
Heme/ Oncology			
Endocrinologist			
Vascular Medicine			
Psychiatrist			
Urologist			
Pain Management			
Cardiologist			

Occupation/Retired ______________________

Married/ Divorced/ Single/Widowed Lives With _______________

Education: High School/ College/ Post Grad:______________________

Caffeinated Beverage _____ day/ Week/ Month

Cigarette/ Cigar/ Chew _______ day/ week/ month Quit Y/ N Date ________

Alcohol _____ beer/ wine/ liquor day/ week/ month Quit Y/ N Date ________

Marijuana/ Cocaine/ Heroin/ Meth for ____ years IV Y/ N Quit Y/ N

Your History (circle all that apply)

Alcoholism	Depression	Memory Problems
Allergies	Diabetes	Multiple Sclerosis
Anemia	Epilepsy	Muscle Pain
Aneurysm	Glaucoma	Neuropathy
Anxiety	Headaches	Parkinson's Disease
Arthritis	Head Trauma	Peripheral Vascular
Back/ Neck Pain	Heart Disease	Thyroid Disease
Blood Clot Date _______ Location ____________	High Blood Pressure	Rheumatoid Arthritis
Blood Transfusion	High Cholesterol	Sleep Issues
Bowel/ Bladder Problems	Lung Disease	Tremor
Cancer Type _________ Chemo _____ RT _____	Lupus	

Family History Does anyone in your family have a history of (circle all that apply and indicate your relationship)

	Mother	Father	Sister	Brother	Grand-mother	Grand - father
Aneurysm						
Blood Clot						
Cancer_______ Type ________						
Dementia						
Depression						
Diabetes						
Headaches						
Heart Disease						
High Cholesterol						
Multiple Sclerosis						
Neuropathy						
Parkinson's						
Seizures						
Stroke / TIA						
Substance Abuse						
Thyroid Disease						

Medication

(If you have a medication list already prepared you may just attach a copy)

Medicine	Dose	Frequency	Prescribed By	Start date	Reason

Allergies

________ No Known Allergies

Drug	**What Kind of Reaction**	**Mild / Moderate / Severe**

Previous Studies (Mandatory to Bring reports with new patient packet)

	Where	When	Phone
Cerebral Angiogram			
CT Abdomen/ Pelvis			
CT Head/ Pelvis			
Carotid Ultrasound			
Echocardiogram			
EEG			
Holter Monitor			
Last Blood Work			
Last Ultrasound			
MRI			
Nerve Conduction			
Spinal Tap			

Surgeries

Appendectomy	Gallbladder	Knee Surgery R/ L
Back Surgery	Heart Surgery	Neck Surgery R/ L
Brain Surgery	Hip Surgery R/ L	Shoulder Surgery R/ L
Cardiac Cath	Hysterectomy	Other:

Review of Systems (Please circle all that apply)

CONSTITUTIONAL	**EARS**	**NOSE**	**RESP**
Fever	Clogged ears	Change in sense of smell	Chest tightness
Chills	Earaches	Itchy nose	Cough at night
Excessive sweating	Recurrent infections	Nasal congestion	Coughing up blood
Lack of Appetite	Ringing or popping ears	Nasal discharge	Dry cough
Insomnia	Vertigo	Nasal polyps	Frequent bronchitis/ Chest cold
Fatigue		Nose bleeding	Frequent coughing
		Runny nose	Recurrent Pneumonia
Mouth/Throat	**Neck**	Sneezing	Shortness of breath
Difficulty swallowing	Stiffness		Wet cough
Drip in the back of throat	Pain	**Cardio**	Wheezing
Excessive Snoring	Tenderness	Chest Pains	**GI**
Hoarseness/ Laryngitis	Noted Mass	Angina	Abdominal Pain
Mouth Breathing		Swelling	Diarrhea
Sore Throat	**Skeletal**	Palpitations	Constipation
Swollen Tongue	Arthritis		Heartburn/Indigestion
Throat Tightness	Back Pain	**Skin**	Nausea
	Fractures	Rash	Vomiting
Urinary	Muscle Pain	Hives	
Frequency		Persistent Itch	**Neuro**
Pain Urinating		Recurrent Abscess	Weakness
Urgency	**Heme/Lymph**	Lesion	Numbness
Bloody Discharge	Anemia	Abrasions	Dizziness
Discharge	Bleeding Disorders	Swelling	Seizures
Bleeding	Easy Bruising		Headache
	Swollen Glands		Loss of Consciousness
Endocrine			Unsteady Gait
Diabetes			
Excessive Thirst			

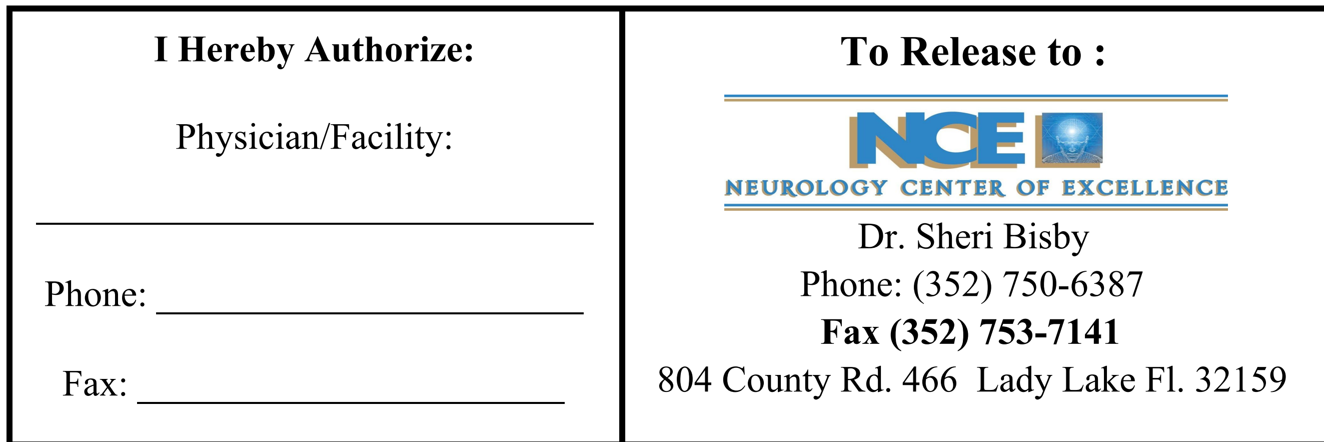
PT Scheduled Appointment ______________

Medical Release Form

Patient's name ________________________________ DOB_________________

SSN: ___________________ Phone_________________________

Purpose of Release: ❑Personal ❑ Physician Change ❑ Continuation of Care



I Hereby Authorize:	**To Release to :**
Physician/Facility: ______________________________	NCE NEUROLOGY CENTER OF EXCELLENCE
Phone: _______________________	Dr. Sheri Bisby Phone: (352) 750-6387 **Fax (352) 753-7141**
Fax: _______________________	804 County Rd. 466 Lady Lake Fl. 32159

❑ Complete Medical Record

❑ Progress Report

❑ Lab/Pathology Report

❑ Radiology

❑ TWO years prior from last date seen

❑ Other (describe specifically):

____

____

This authorization shall expire no later than: ____/_____/_____ or upon the following event ___________________ (whichever is sooner), and may not be valid for greater than one year from the date of signature. You have a right to revoke this authorization. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

____ ________________

Signature of patient (or patient's personal representative) Date

______________________________ ____________________________________

Printed name of patient or representative

Representative's authority to sign for patient
(i.e. parent, guardian, power of attorney)

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Patient Agreement

(Please initial each paragraph)

_____ I understand that a copy of the Notice of Privacy Practices for the office of Sheri Bisby, MD is available to me upon request. By signing this form I acknowledge that I have either received and reviewed a copy of the privacy or have declined receiving or reviewing a copy.

_____ I request a payment of authorized Medicare and/or other insurance benefits including supplemental and auto insurance benefits to be paid directly to this provider. I authorize the release of any information concerning my health care or treatment provided to me by insurance carrier and the agents to determine benefits payable.

_____ In the event that a copy of my personal health information is needed for reasons other than immediate treatment. I hereby authorize Sheri Bisby, MD and staff to release my personal Health Information to the following persons acting on my behalf.

Patient Name ____________________________________ DOB______________

Signature ____________________________________Date __________________

Relationship_______________________________

Medical Information Release Form

(HIPAA Release Form)

Name: ______________________________ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse______________________________

[ ] Child(ren)______________________________

[ ] Other______________________________

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ______________________________

The best time to reach me is (*day*)________________ between (*time*)________

Signed: ______________________________ Date: ____/____/____

Witness:______________________________ Date: ____/____/____

IDS Instant Diagnostic Systems

Patient Self-Screening Form
S.T.O.P. / Epworth Sleepiness Scale

Treating Physician: NPI -

Last Name:_______________ First:_______________

Birth Date:_________ ☐ Male ☐ Female Height:_____ Weight:_____ Neck Circumference (or Collar Size)_____

The S.T.O.P. Quiz

		Yes	No
1. Snoring	**Do you snore loudly?**	☐	☐
2. Tired	**Do you often feel tired, fatigued, or sleepy during the daytime?**	☐	☐
3. Observed	**Has anyone observed you stop breathing (choking, gasping) during your sleep?**	☐	☐
4. Pressure	**Do you have, or are you being treated for high blood pressure?**	☐	☐

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to think about how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = *Never* doze **2 = *Moderate* Chance of dozing**
1 = *Slight* chance of dozing **3 = *High* Chance of dozing**

Chance of Dozing Score 0-3:	Situation:
____	Sitting and reading
____	Watching TV
____	Sitting, inactive in a public place (i.e. a theater or in a meeting)
____	As a passenger in a car for an hour without a break
____	Lying down to rest in the afternoon when circumstances permit
____	Sitting and talking to someone
____	Sitting quietly after a lunch without alcohol
____	In a car while stopping for a few minutes in traffic
____	**TOTAL (This is your Epworth Score!)**

Summary:

Discuss results with your physician as soon as possible about your high risk for sleep apnea if:

☐ You answered 'YES' to TWO or more questions in the Stop Quiz, **or** ONE YES and you fit any of the following criteria: Male - Over 50 - Overweight - Large Neck Circumference (collar size).

OR...

☐ Your "Epworth Sleepiness Scale" Score total is 9 or higher

Disclaimer: The validated questionnaires on this form are intended to help assess patients that may be at risk for OSA. It is not intended to replace clinical judgement of the treating physician in the diagnosis of OSA.
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