Marshall Allyn White. MD

Neurology & Pain Management

Full Name:_____ Social Security #_____
Address:_____ Email:_____
City:_____ Sate:_____ Zip Code:_____
Home phone:_____ Work phone:_____
Mobile phone:_____
Sex:_____ Date of Birth:_____ Age: _____
Martial Status: Single _____ Married___ Divorced_____
Employer:_____ Occupation:_____
Responsible Party/Guarantor:_____
Family Doctor:_____ Phone# _____
In case of emergency, _____ Relationship_____
contact Address:_____ Phone# _____

If patient is a minor: Mother or Father's name_____
Address (if different from above)

I selected this office because:
_____Billboard
_____Print Ad (please specify which publication)
_____Search Engine
_____Social Media (please specify)
_____Referral (name of person or Dr._____)
_____Walk-in

Acknowledgement of Receipt of Privacy Practices

Marshall Allyn White, MD Neurology & Pain Management Reserves the right to modify the privacy practices outlined in this notice.
We are required by Law to maintain the privacy of individuals with this notice of our *legal* duties and privacy practice with respect to protected health information. Signature below is only an acknowledgement that you have received a Notice of Privacy Practices.

Signature of patient:_____ Date:_____

Signature of Legal Guardian or Representative if patient is a minor:_____.

I authorize Marshall Allyn White, MD Neurology & Pain Management to release or receive from other healthcare providers any medical information that may be necessary for medical care or in the processing of applications for financial benefit. I understand the Health Insurance Portability and Accountability Act of 1996. I understand that this authorization covers only information necessary to conduct, plan and direct treatment and follow up and conduct normal healthcare operations.

I further understand that payment in full is due at the time of service.

Signature of Patient:_____ Date:_____
Witness:_____ Date:_____
Parent or Legal Guardian:_____ Date_____

A photocopy of this authorization shall be valid as the original

Marshall Allyn White, M D
1275 Ben Sawyer Blvd, Suite B
Mount Pleasant, SC 29464
(843) 696-3705 Fax: (843) 388-5839
www.drmwhite.com

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PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____

CHIEF COMPLAINT (REASON FOR VISIT):

HISTORY OF YOUR PRESENT ILLNESS (EXPLAIN PROBLEM IN DETAIL):

_____

_____

_____

_____

HAVE YOU HAD TESTING OR TREATMENT FOR THIS PROBLEM? (MRI, CT, LABWORK, ETC.)

TEST/PROCEDURE: **FACILITY:** **DATE:**

_____

REVIEW OF SYSTEMS
(PLEASE CHECK ALL THAT YOU HAVE HAD OR MAY BE EXPERIENCING)

NAUSEA	RECENT WEIGHT LOSS	**NUMBNESS (WHERE)**
VOMITING	LOSS OF APPETITE	TINGLING (WHERE)
FEVER	RASH/HIVES	BURNING (WHERE)
CHILLS	BRUISING	MEMORY LOSS
DIARRHEA	EDEMA (SWELLING) WHERE?	DIZZY SPELLS
CONSTIPATION	SLEEP DISORDER	BLURRED VISION
SHORTNESS OF BREATH	DIFFICULTY SLEEPING	OTHER
CHEST PAIN	DROWSINESS	
LEG PAIN	LOSS OF CONSCIOUSNESS	
MUSCLE WEAKNESS	HEADACHES	ARM PAIN
BACK PAIN	NECK PAIN	CHRONIC COUGH
HYPERHIDROSIS (WHICH AREA OF THE BODY)		

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FAMILY HISTORY:

SEIZURE DISORDER	ANEMIA	HIGH CHOLESTEROL
MIGRAINES	BLOOD DISORDER(WHICH?)	ALCOHOLISM
MENTAL ILLNESS (WHICH?)	ASTHMA	CANCER
DIABETES	OSTEOPOROSIS	ATHRITIS
GLAUCOMA	HIGH BLOOD PRESSURE	KIDNEY DISEASE
HYPERTHYROIDISM	HEART DISEASE/FAILURE	LIVER DISEASE
	STROKE	OTHER

CURRENT MEDICATIONS:

1.	6.
2.	7.
3.	8.
4.	9.
5	10.

MEDICAL HISTORY:

HEART ATTACK (#?___)	ANEMIA	THYROID DISEASE (HYPO HYPER)
RENAL	ASTHMA	BLEEDING DISORDERS
CANCER (TYPE__)	LOWER GI DISORDER	STROKE
GOUT	SEIZURE DISORDER	ARTHRITIS
SINUS TROUBLE	RHEUMATISM	CHEST PAIN
A NEURYSM (WHERE?)	TUBERCULOSIS	LEG PAIN (PHLEBITIS?)
DEPRESSION/ANXIETY	MENTAL ILLNESS	HISTORY OF STDS (WHICH?)
HIGH CHOLESTEROL	AIDS/HIV POSITIVE	OTHER

SOCIAL HISTORY:

DO YOU DRINK ALCOHOL? YES NO HOW MANY DRINKS PER WEEK? ___

DO YOU USE TOBACCO? YES NO WHICH TYPE? _____ HOW OFTEN/HOW MUCH?_____

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DO YOU USE ANY OTHER RECREATIONAL DRUGS? YES NO IF SO, WHICH TYPE?_____

OCCUPATIONAL STATUS: FULL TIME PART TIME RETIRED DISABLED

WHAT WAS YOUR OCCUPATION?_____

SURGICAL HISTORY

PLEASE LIST ANY SURGERIES THAT YOU HAVE HAD PERFORMED IN THE PAST.

1. _____ DATE: _____
2. _____ DATE: _____
3. _____ DATE: _____

PLEASE LIST ANY ALLERGIES THAT YOU MAY HAVE:

1. _____
2. _____
3. _____
4. _____

VITALS (TO BE FILLED OUT BY NURSE):

BP: _____ **PULSE:** _____ **RESPIRATIONS:** _____

HEIGHT: _____ **WEIGHT:** _____

NOTES (TO BE FILLED OUT BY NURSE/PHYSICIAN):

ASSESSMENT:

PLAN:

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Private Contract - Provider Opt-Out of Medicare

Provider Name: Marshall Allyn White, MD (SC Lic. NO. 13431)

Provider Address: 1275 Ben Sawyer Blvd., Suite B

City: Mt. Pleasant State: SC Zip Code: 29464

Beneficiary Name:

Legal Representative (if applicable):

Beneficiary Medicare Number:

This private contract agreement is between the physician and beneficiary noted above. The beneficiary is a Medicare Part B beneficiary and is seeking services covered under Medicare Part B. The physician above has informed the beneficiary or his/her legal representative they have opted-out of the Medicare Program. The current Medicare opt-out period is from June 16, 2015 to June 16, 2017 . The physician noted above is not excluded from participating in Medicare Part B under §§1128, 1156 or 1892 of the Act.

The beneficiary or his/her legal representative has read and agree to the following terms of the private contract by placing their initials by the items below:

☒ I, or my legal representative, accept full responsibility for payment of the physician's or practitioner's charge for all services furnished by this physician/practitioner;

☒ I, or my legal representative, understands that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner;

☒ I, or my legal representative, agree not to submit a claim to Medicare or to ask the physician/practitioner to submit a claim to Medicare;

☒ I, or my legal representative, have been informed of the expected or known expiration date of the opt-out period; which is June 16, 2015 to June 16, 2017 ;

☒ I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;

☒ I, or my legal representative, enter into the contract with the knowledge that the beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out;

☒ I, or my legal representative, understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare;

☒ I, or my legal representative, agree this contract was not entered into during a time when the beneficiary required emergency care services or urgent care services.

Date

Beneficiary or Legal Representative's Signature

Date

Physician's Signature