



Shivani Shah, DO, MPH

PEDIATRIC NEUROLOGY PATIENT INTAKE FORM

Please complete all sections as thoroughly as possible. This information helps us provide the best possible care for your child.

PATIENT INFORMATION

Patient Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Age: _____

Gender: ☐ Male ☐ Female ☐ Other

Preferred Name: _____

Referring Physician: _____

Home Address: _____

City / State / ZIP: _____

Home Phone: _____

Primary Care Physician: _____

Pharmacy name and number: _____

PARENT / GUARDIAN INFORMATION

Parent/Guardian 1 Name: _____

Relationship to Patient: _____

Cell Phone: _____

Email: _____

Parent/Guardian 2 Name: _____

Relationship to Patient: _____

Cell Phone: _____

Email: _____

Emergency Contact (Name & Phone): _____

Insurance Provider & Policy / Group #: _____

REASON FOR TODAY'S VISIT

Chief concern / reason for referral:

MEDICAL HISTORY

Current medications (name, dose, frequency): _____

Allergies (medication, food, environmental): _____

Past surgeries or hospitalizations: _____



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Chronic medical conditions: _____

☐ Immunizations up to date ☐ Immunizations delayed/incomplete

Method of Payment

☐ Cash ☐ Credit Card

Please note that we do not accept personal checks. If payment is made by credit card, there will be a 3% processing fee.

HIPAA and Assignment of Insurance Benefits

- As per HIPAA Act of 1996, I acknowledge that I have been given the opportunity to read the "Notice of Privacy Practices" posted in the office. I further acknowledge that I have been given the opportunity to have a copy of this policy.
- I hereby authorize direct payment of medical benefits to Dr. Shah for services rendered by her or under her supervision. I understand that I am financially responsible for any balance not covered by insurance. Photocopy of this release will be valid as the original.

Parent/Guardian Signature or self: _____

Date: _____

Printed Name: _____

Relationship to Patient: _____