Neurology Specialists

******PATIENT INFORMATION******

PATIENT_______________ DATE OF BIRTH_______________ AGE_______

ADDRESS_______________ APT / SP #_______________

CITY_______________ STATE__________ ZIP__________

PHONE#_______________ SEX_____ RACE_______________ ETHNICITY_______________

EMAIL ADDRESS_______________

SOC.SEC#_______________ MARITAL STATUS _________

PEDIATRICIAN / FAMILY DOCTOR_______________ GROUP_______________

ADDRESS _______________ CITY__________ STATE______ ZIP______

PHONE#_______________ FAX#_______________

******GUARANTORS INFORMATION******

MOTHER/GUARDIAN_______________ SOC SEC.#_______________

ADDRESS_______________ APT / SP #_______________

CITY_______________ STATE__________ ZIP__________

PHONE#__________ CELL #__________ SEX_____ MARITAL STATUS_______ DATE OF BIRTH__________

EMPLOYER_______________ WORK PHONE#_______________ DEPT__________

FATHER/GUARDIAN_______________ SOC SEC.#_______________

ADDRESS_______________ APT / SP #_______________

CITY_______________ STATE__________ ZIP__________

PHONE#__________ CELL #__________ SEX_____ MARITAL STATUS_______ DATE OF BIRTH__________

EMPLOYER_______________ WORK PHONE#_______________ DEPT__________

******INSURANCE INFORMATION******

PRIMARY INSURANCE CO_______________ PHONE_______________

ADDRESS_______________ CITY__________ STATE______ ZIP______

POLICY HOLDERS NAME_______________ DATE OF BIRTH______ SS#_______________

POLICY # _______________ GROUP#_______________ EFFECTIVE DATE__________

SECONDARY INSURANCE CO_______________ PHONE_______________

ADDRESS_______________ CITY__________ STATE______ ZIP______

POLICY HOLDERS NAME_______________ DATE OF BIRTH______ SS#_______________

POLICY # _______________ GROUP#_______________ EFFECTIVE DATE__________

The above information is complete and correct. I hereby authorize release of information to the referring doctor and/or the pediatrician/family doctor. I hereby authorize release of information to all parents, guardians or guarantors, listed above. I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me, to the doctor or group indicated on the claim. I understand that I am responsible for all charges for medical services rendered regardless of insurance coverage. A copy of the signature is as valid as the original.

PATIENT, PARENT OR GUARDIAN SIGNATURE_______________ DATE__________

Neurology Specialists

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of the **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law.

Print Patient Full Name: ____

Print Parent / Guardian Name: ____

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Parent / Guardian / Patient Signature **Date**

NEUROLOGY SPECIALISTS EVALUATION QUESTIONAIRE

(FOR CHILDREN UNDER 18 YEARS OF AGE)

GENERAL INFORMATION

TODAY'S DATE___________________________

NAME OF PATIENT____

AGE______________ BIRTH DATE________________________ LEFT/RIGHT HANDED (circle)

REFERRING DOCTOR OR PEDIATRICIAN____

REASON FOR VISIT____

DRUG ALLERGIES____

CURRENT MEDICATIONS ____

____

PREGNANCY (MOTHER'S PREGNANCY WITH PATIENT)

ARE YOU THE BIOLOGICAL PARENT/PARENTS____

WAS THE MOTHER'S PREGNANCY FULL TERM____

LIST ALL MEDICATIONS TAKEN WHILE PREGNANT____

ILLNESSES DURING PREGNANCY (LIST MONTH)____

LABOR AND DELIVERY (MOTHER'S PREGNANCY WITH PATIENT)

BREECH OR UNUSUAL PRESENTATION____

VAGINAL DELIVERY OR C SECTION____

IF C SECTION, WHAT WAS THE REASON____

BIRTH WEIGHT OF BABY_________________________ LENGTH OF HOSPITAL STAY________

WERE THERE ANY COMPLICATIONS SOON AFTER THE BABY WAS BORN_______________

____

DEVELOPMENTAL HISTORY (LIST THE AGE THE SKILL WAS ATTAINED)

ROLLED OVER____________________________ CRAWLED_______________________________

WALKED ASSISTED________________________ WALKED UNASSISTED___________________

SPOKE SENTENCES________________________

SOCIAL / EDUCATION HISTORY

PATIENT'S GRADE____

SPECIAL EDUCATION SETTING LIKE RESOURCE ROOM, IEP, OR 504 PLAN_______________

____

PAST MEDICAL HISTORY

ANY TIME YOUR CHILD HAS BEEN ADMITTED TO A HOSPITAL

AGE_______________ REASON____

AGE_______________ REASON____

ANY HISTORY OF HEAD INJURY WITH LOSS OF CONSCIOUSNESS AND VOMITTING

____

ANY HISTORY OF SEIZURE____

ANY PROBLEMS WITH VISION OR HEARING____

ANY ASTHMA / HIGH BLOOD PRESSURE / DIABETES / LUNG / LIVER / STOMACH /

BLADDER / BOWEL / HEART PROBLEMS____

ANY SLEEPING PROBLEMS____

BED WETTING_____________________________________ ARE SHOTS CURRENT_______________

FAMILY HISTORY

HOW MANY SIBLINGS (BROTHERS/SISTERS) DOES YOUR CHILD HAVE___________________

WHO DOES THE CHILD LIVE WITH____

FAMILY HISTORY (SPECIFY RELATIOSHIP) OF SEIZURES / MENTAL RETARDATION /

PSYCHIATRIC PROBLEMS / ADHD / OBSESSIVE COMPULSIVE DISORDER / DEPRESSION /

TOURETTE SYNDROME OR TICS____

____

____

ANY OTHER INFORMATION HELPFUL TO THE DOCTOR FOR THIS VISIT______________

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