Patient Information

Date:

Name:

Address:

Home Phone: **Cell Phone:** _ **SSN:** _

Sex: _ **Age:** _ **Birthdate:** _ **Marital Status:** _

Race: **Ethnicity:** **Preferred Language:** **Email:**

Patient Employer/School: **Occupation:**

Employer/School Address: **Employer/School Phone:**

Whom may we thank for referring you?

In case of emergency, who should be notified? **Phone:**

Primary Insurance:

Person Responsible for Account: **Relationship to Patient:**

Address (if different from patient's):

Birthdate: **SSN:** **Phone:**

Insurance Company: _ **ID Number:** _ **Group Number:** _

Secondary Insurance:

Person Responsible for Account: **Relationship to Patient:**

Address (if different from patient's):

Birthdate: **SSN:** **Phone:**

Insurance Company: _ **ID Number:** _ **Group Number:** _

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with (name of insurance company) and assign directly to Neurology Outreach Clinics, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or tch benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Sign

Signature of Patient, Parent, Guardian, or Personal Representative Date

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Pediatric Health and History Data

Date: Referring Doctor:

Child Accompanied By: Family Doctor:

Pediatric Doctor:

Dear Parent:

Please complete this form in its entirety. This information is a vital adjunct to the child's examination and aid the Dr. in completing his diagnosis.

Patient's Name: Birth Date: _

Parent/Guardian: Child Lives With:

Parent/Guardian Daytime Phone #:

Please explain why the child is to see the Dr. :

Social History:

Father's Name: Age: Occupation:

Circle highest # of years of father's education 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 more

Mother's Name: Age: Occupation:

Circle highest # of years of mother's education 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 more

Marital Status of Parents:

# of Siblings: *Full:* Male Female *Half*: Male Female *Step*: Male Female

Any significant stressors? ☐ School ☐ Home ☐ Other

Family Medical History:

Is there any family history of: (indicate maternal or paternal relative)

Birth Defects:
Mental Retardation:
Learning Disability:
Difficulty Walking/Staggering:
Cerebral Palsy:
Dementia:
Diabetes:
Unusual Muscular Movements:
Weakness:
Seizures/Epilepsy:
Sick Headaches/Migraines:
Blindness:
Psychiatric Condition:
Hypertension:

Mother's Pregnancy History:

Expected Due Date: This was mother's: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th pregnancy

List any medications taken by mother during pregnancy:

During the pregnancy, did mother: ☐ Smoke ☐ Drink Alcoholic Beverages ☐ Use Street Drugs How much?

List any problems/illness/spotting or bleeding that occurred during the pregnancy and which trimester:

Problem: Trimester:
Problem: Trimester:
Problem: Trimester:
Problem: Trimester:

Labor & Delivery:

Name of Hospital where baby was born: Did the baby cry immediately after birth? ☐ Yes ☐ No

Birth Weight: Birth Head Circumference:

Type of Delivery: ☐ Vaginal ☐ C-Section Labor was: ☐ Spontaneous ☐ Induced Duration of Labor: Hours

At any time during labor or delivery: ☐was baby in fetal distress ☐cord around baby's neck

☐ having "decels" or decreased heart rate ☐ meconium stained amniotic fluid

☐ mom have high blood pressure ☐ hemorrhage (mom)

☐ other problems:

Were forceps used to deliver the baby: ☐ No ☐ Yes Mother used what type of anesthetic: ☐ General ☐ Spine ☐ None

Apgar scores at 1 min: 5 min:

Was baby born premature: ☐ No ☐ Yes If yes, how many weeks

Was baby born past due date: ☐ No ☐ Yes If yes, how many weeks

Was baby cared for in the NICU: ☐ No ☐ Yes If yes, where:

Was oxygen administered: ☐ No ☐ Yes

Ventilator: ☐ No ☐ Yes how long: *Oxyhood*: ☐ No ☐ Yes how long:

How long was the baby in the hospital:

Development:

Indicate the age that the child attained the following skills:

Follow with eyes	Simple word phrases	Laugh out loud	Complete sentences
Head control	Run	Rolled over	Toilet trained
Sit alone	Fed self with spoon	Rode tricycle	Crawled
Dress self	Pulled to standing	First words	Fed self finger foods
Color in lines	Walk unassisted	Rode bicycle	Tied shoelace

Medical History:

List dates and describe problems of following:

Does the child have any chronic or congenital illness or problems:

Have any special tests or procedures been done? What? Where?

What doctors have treated the child for chronic or congenital problems?

Are immunizations current? ☐ No ☐ Yes Date of last TB Immunization:

List allergies:

List medication allergies:

Feeding difficulties:

Major infections:

Has the child ever been poisoned:

Surgeries:

Hospitalizations:

Has the child ever been unconscious:

Severe trauma or injuries:

Any severe head injury:

Is there any use of ☐ tobacco ☐ alcohol ☐ drugs Menstruation is ☐ Regular ☐ Abnormal

School: Grade: Performance: ☐ Good ☐ Average ☐ Poor

Patient Name:
Patient DOB: _

I wish to be contacted in the following manner (check all that apply)
☐ Home Telephone ☐ O.K. to leave message with detailed information ☐ Leave message with call back number only
☐ Work Telephone ☐ O.K. to leave message with detailed information ☐ Leave message with call back number only
☐ Written Communication ☐ O.K. to mail to my home address ☐ O.K. to mail to my work/office address ☐ O.K. to fax to this number
☐ Other

Sign

Patient Signature

Date

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name:
Patient DOB: _

Sign

Patient Signature

Date