Neurology Associates, PA

Pediatric Patient Information Form

Patient Name: ______________________________ **Birth Date**: ______________
First *Middle* *Last*

School: ________________ **School Phone**: ______________

Interpreter Name: ______________________________ **Phone Number**: ______________

Primary Parent Contact	**Secondary Parent Contact**
Name: ______________________	Name: ______________________
Relationship to Patient: ______________	Relationship to Patient: ______________
Daytime Phone: ______________	Daytime Phone: ______________
Evening Phone: ______________	Evening Phone: ______________
Mobile Phone: ______________	Mobile Phone: ______________
Other phone / pager: ______________	Other phone / pager: ______________
Email address: ______________	Email address: ______________
Is there any place on this list where we should <u>not</u> leave a message? ______________________	Is there any place on this list where we should <u>not</u> leave a message? ______________________
☐ Child lives with this parent.	☐ Child lives with this parent.

Complete the following if you will not always accompany your child to their appointment:

<u>CONSENT FOR TREATMENT OF UNACCOMPANIED MINOR</u>

I acknowledge that I am the parent or guardian entitled to the care, custody, and control of Minor.

In the event that I am unable to accompany Minor to his/her appointment, I authorize the healthcare providers of Neurology Associates, PA to examine and treat Minor in my absence.

Name: ______________________

Signature: ______________________ **Date:** ______________

Relationship: ______________________

Witness: ______________________ **Date:** ______________

Neurology Associates, PA

CONSENT FOR TREATMENT OF UNACCOMPANIED MINOR

Name of Minor: ___________________________ (“Minor”)

Date of Birth of Minor: _______________

I acknowledge that I am the parent or guardian entitled to the care, custody, and control of Minor.

In the event that I am unable to accompany Minor to his/her appointment, I authorize the healthcare providers of Neurology Associates, PA to examine and treat Minor in my absence.

Name: __________________________

Signature: ______________________ Date: _________________

Relationship: ____________________

Witness: _______________________ Date: __________________

Neurology Associates, PA

Patient Name: ______________________

Authorization for Treatment

I hereby authorize such examinations, treatments, medications, tests, and procedures as may be prescribed by the Neurology Associates, PA physician or physician assistant in charge of my care.

Acceptance of Financial Responsibility

I understand that I am directly responsible for all medical expenses regardless of insurance coverage and whether or not treatment is needed as a result of an accident in which another person is at fault. I understand that I am responsible for any deductibles, co-pays, co-insurance or amounts for services not covered by my insurance carrier.

Assignment of Benefits

I hereby authorize payment by my insurance carrier directly to Neurology Associates, PA for any physician and/or medical services or benefits.

Designation of Personal Representative

I hereby designate the following individual(s) as my personal representative(s) and authorize Neurology Associates, PA to release any verbal or written information about me to my personal representatives as may be needed to assist with my ongoing treatment. This designation and authorization will remain in effect until revoked by me in writing.

Personal Representative Name	Relationship
______________________________	________________
______________________________	________________
______________________________	________________

By signing this document I acknowledge that I understand and agree to the foregoing terms and conditions.

______________________________ ________________
(Signature of Patient, Parent or Guardian) (Date)

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that Neurology Associates, PA will use and disclose my personal health information according to Neurology Associates, PA's Notice of Privacy Practices (the "Notice"). I acknowledge that I have received a copy of the Notice.

______________________________ ________________
(Signature of Patient, Parent or Guardian) (Date)

Neurology Associates, PA

NA #___________

Patient Medical History

Name___________________________**Date of Birth**_________**Today's Date**_________**Referring Dr.**______________

Past Medical History: Check all that you have or have had in the past:

__AIDS/HIV	__Cancer	__High Blood Pressure	__Sinus Problems
__Alzheimer's	__Depression	__High Cholesterol	__Sleep Problems
__Anemia	__Diabetes	__Sleep Apnea	__Snoring
__Anxiety	__Headaches/Migraines	__Parkinson's Disease	__Stroke
__Arthritis	__Heart Disease	__Restless Leg Syndrome	Other:__________________
__Asthma	__Hepatitis	__Seizures	________________________

Surgical Procedures and Dates: ☐ **Check here if you have had no prior surgeries**

Pharmacy Name & Location:____

Medications: (Include prescriptions, over the counter medications, vitamins, & hormones, etc.)**:**

☐ **Check here if you take NO medications**

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Drug Allergies and Reactions: ☐ **Check here if you have no known drug allergies**

Have you ever had a reaction to IV dye?___________

Family History: Use correct letter(s) to show if an immediate family member has had any of the problems listed:

Mother=M	**Grandmother:**	**Mother's Mother=MGM**	**Father's Mother=PGM**	**Sister=S**
Father=F	**Grandfather:**	**Mother's Father=MGF**	**Father's Father=PGF**	**Brother=B**

_____Alzheimer's	_____Cancer	_____High Blood Pressure	_____Seizures	_____Stroke
_____Anemia	_____Diabetes	_____High Cholesterol	_____Sinus Problems	
_____Arthritis	_____Headaches/Migraines	_____Sleep Apnea	_____Sleep Problems	
_____Asthma	_____Heart Disease	_____Parkinson's Disease	_____Snoring	

Social History:

Alcohol Use:	☐ Do not use	☐ Social drinker	#Drinks/week___	
Tobacco Use:	☐ Do not use	☐ Smokes	# Packs/Day___	☐ Oral tobacco
Drug Use:	☐ Do not use	☐ Marijuana	☐ IV drugs	Other:___________
Marital Status:	☐ Single ☐ Marrried ☐ Divorced ☐ Widowed		**Education Level:** ________________________	
Occupation:		**Employer:**		

(Continue on other side of form)

General Health: Check all that you have had in the past 3 months. ☐ **Check here if pregnant**

__Fatigue	__Nose bleeds	__Abdominal pain	__Muscle weakness	__Problem focusing
__Fever/Chills	__Ringing in ears	__Constipation	__Neck pain	__Disturbing thoughts
__Loss of Appetite	__Postnasal drip	__Diarrhea	__Shooting pain	__Hyperactivity
__Night Sweats	__Sinusitis	__Swallowing problem	__Change in moles	__Moodiness
__Sleep disturbance	__Sore throat	__Heartburn	__Skin lumps	__Suicidal thoughts
__Weight gain/loss	__Sores in mouth	__Hemorrhoids	__Skin rashes	__Homicidal thoughts
__Double Vision	__Vertigo	__Indigestion	__Blackouts/fainting	__Change in periods
__Eye discharge	__Chest pain at rest	__Nausea/Vomiting	__Speech difficulty	__Excessive sweating
__Eye pain/soreness	__Chest pain/exercise	__Difficulty urinating	__Headache/Migraines	__Problem w/heat/cold
__Vision loss	__Blue skin color	__Frequent urination	__Memory loss	__Excessive thirst
__Blurred vision	__Palpitations	__Blood in urine	__Paralysis/weakness	__Excessive hunger
__Itchy eyes	__Shortness of breath	__Bladder control loss	__Numbness	__Abnormal bleeding
__Red eyes	__Ankle swelling	__Painful urination	__Seizures	__Anemia
__Swollen eyes	__Cough/Croup	__Back pain	__Tingling	__Bruising
__Dizziness	__Cough up blood	__Joint pain	__Tremors	
__Hearing loss	__Snoring	__Joint stiffness	__Anxiety	
__Hoarseness	__Rapid breathing	__Limited movement	__Sleep changes	
__Nasal Obstruction	__Wheezing	__Muscle pain/cramps	__Depression	

Sleep Patterns: How likely are you to doze off or fall asleep (not just feel tired) in the following situations?

Situation	**Never=0**	**Slight chance=1**	**Moderate chance=2**	**High Chance=3**
Sitting & reading				
Watching TV				
Sitting inactive in a public place like a theater or meeting				
Riding as a passenger in a car for an hour without a break				
Lying down to rest in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car while stopped for a few minutes				
Column Total				

Add Column Totals for Total Score_________

Average amount of sleep you get most nights_________

Check one: After a full night of sleep, you feel ☐Rested and refreshed or ☐Excessively tired throughout the day.

Do you kick your feet or legs throughout the night? Yes /No

Do you suffer from morning headaches? Yes /No

Do you snore loudly? Yes /No

Do you stop breathing in your sleep? Yes /No

Insomnia Scale: If you have sleep difficulty/insomnia, complete this section:

How many nights a week do you have problems falling asleep or staying asleep? ________

How long have you had this problem? ________________

Rate the severity of the following problems in the chart below:

	No Problems=0	**Mild Problem=1**	**Moderate Problem=2**	**Severe Problem=3**
Problems falling asleep				
Difficulty staying asleep/frequent awakenings				
Awakening earlier than you wish				
Daytime sleepiness				
Poor/impaired function at home or work				
Mood swings				
Memory loss				
Being hyperactive, anxious, or nervous during the day				
Column Total				

Add Column Totals for Total Score_________

Patient Signature____