Neurology Specialists
an affiliate of MEDNAX

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 _____GROUP_____

DOCTOR **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: _____

_____

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_____

_____

_____

_____

_____