

NORAN NEUROLOGICAL CLINIC



Welcome to the Noran Neurological Clinic. In preparation for your first visit we are sending you some forms to review and complete prior to your appointment. The questions relate to your current medications and past medical history. We are also enclosing various authorizations as well as our privacy policy. Please bring the completed forms, as well as any records that might assist our physicians in your care; recent imaging (MRIs, CTs, or Xrays) can be particularly useful to have with you at your appointment.

We ask that you arrive at least 15 minutes before your appointment time to allow time to check in and review any additional forms that may be needed. Due to a new federal law designed to protect consumers from identity theft, we have to ask you to bring a government issued photo ID to your appointment. We're doing this to make sure no one else can use your insurance information to get medical treatment.

Payments for copays or any insurance-defined personal responsibility are due at the time of your appointment. As a service to you, our office will bill your insurance company. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances. For your convenience, we accept cash, check, money order, or credit cards including Visa, MasterCard, American Express, and Debit Cards.

If you need assistance with directions to our clinic, please call (612) 879-1600.

If you have questions prior to your visit, or find that you can't keep your appointment, please call (612) 879-1500. Please make any changes to appointment date and time with as much notice as possible, preferably more than 24 hours in advance of your appointment date.

We look forward to providing you with expert and friendly care.

Sincerely,
The Physicians and Staff of the Noran Clinic

P.S. Please ask about our new online patient portal "My Noran Clinic" at your appointment.

Name:
DOB:

Physician:

ACCT#
Gender:

What symptoms or neurologic condition are you being seen for today?

List:

Do you have any other new medical conditions? Yes No Pregnant? Yes No

List:

Have you ever been to the ER or hospitalized recently? Yes No Recent Surgery? Yes No

Details:

Have you had any recent changes in your job or family? Yes No

Details:

Are there any recent changes in your family's health? Yes No

Details:

Review of symptoms (mark below all that apply):

Head

- headache
- loss of vision
- spinning dizziness
- light headedness

Musculoskeletal

- neck pain
- mid back pain
- low back pain
- shoulder pain
- knee pain
- other joint pain

Respiratory

- shortness of breath

Skin

- rash
- hair loss

Other Neurologic

- difficulty concentrating
- memory loss
- trouble walking
- falling
- arm weakness
- leg weakness
- numbness / tingling
- shaking / tremor

Psychiatric

- depression
- anxiety

Gastrointestinal

- vomiting
- loss of bowel control

General

- weight loss
- weight gain

Genitourinary

- frequent urination
- loss of bladder control

Sleep

- snoring
- choking/gasping in sleep
- daytime sleepiness
- morning headaches
- waking feeling unrefreshed
- difficulty falling asleep
- aching/crawling sensation in legs
- neck size 17 inches or larger

Cardiovascular

- palpitations
- swelling of feet

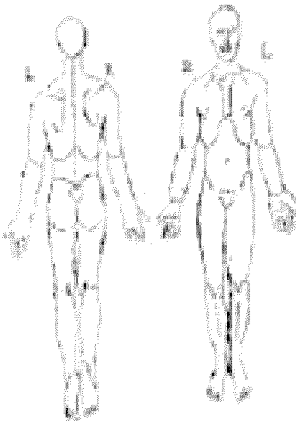
Hematologic/Lymphatic

- bleeding tendency
- blood clots

Other

If you are having pain or numbness

Shade in areas of pain or numbness below:



Work:

Are you working now? yes no

Are hours restricted? yes no

Other restrictions? yes no

List:

If not working:

When did you last work? _____

When might you return to work? _____

Circle the number that relates to your overall level of pain:

(none) 1 2 3 4 5 6 7 8 9 10 (worst)

Signature: _____ Date: _____

Name:
DOB:

Physician:

ACCT#
Gender:

Past Medical History: mark below all that apply to you

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Systemic lupus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Epilepsy / seizures | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Cancer / Tumor | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis | |

Past Surgeries: write below your past surgeries and approximate year none

Past Injuries: write below your injuries and approximate date none

Medications: list drugs and dosing (if known) below

Allergies: list drugs and reaction below

Social History:

Education: How many years of school have you completed? _____ Are you in school now? yes no

Work Status: work FT work PT unemployed laid off temp. disabled perm. disabled retired

Occupation(s): _____ Handedness: right left

Marital status: single partnered married separated divorced widowed

Spouse / Partner: male female Number of children: _____

Tobacco use: yes no Amount and frequency? _____ If quit, when? _____

Alcohol use: yes no Amount and frequency? _____ If quit, when? _____

Caffeine use: yes no Amount and frequency? _____ If quit, when? _____

Family History: mark below if a close relative (immediate family member) has had any of the following problems

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Attention deficit disorder | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Epilepsy / seizures | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Tics / Tourette's |
| <input type="checkbox"/> Birth defect | <input type="checkbox"/> Headaches / migraines | <input type="checkbox"/> Muscle disease | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Brain tumor | <input type="checkbox"/> Huntington's chorea | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Other neurologic |
| <input type="checkbox"/> Brain aneurysm | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Parkinson's disease | |

Mother: living deceased

Father: living deceased

Signature: _____ Date: _____

**NORAN NEUROLOGICAL CLINIC P.A. AND MINNESOTA DIAGNOSTIC CENTER
AUTHORIZATION AND CONSENT FORM**

General Release of Information & Assignment of Benefits:

I authorize Noran Neurological Clinic, on behalf of myself and/or my dependents, to furnish medical records, including films and other information related to health care services provided by Noran Neurological Clinic or the Minnesota Diagnostic Center, to Medicare, my insurance company or other third parties as may be necessary for the payment of a bill, determination of benefits or for utilization and quality review purposes. I hereby assign all authorized medical and surgical benefits to which I am entitled and I request payment of all such authorized benefits be made on my behalf to Noran Neurological Clinic for any services furnished by Noran Neurological Clinic or Minnesota Diagnostic Center.

Payment Agreement:

I understand that I am financially responsible and agree to pay for any charges for the care and treatment rendered to me not covered by my insurance plan or if I do not have active insurance coverage.

Release/Retrieval of Information to/from Health Care Facilities, Pharmacy Benefit Payers and Providers:

I authorize the release or retrieval of my medical treatment information, including films, prescription medication history and other information related to such services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my medical treatment.

Voicemail Messages:

I authorize Noran Neurological Clinic to use and disclose medical information to contact me in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to me. Noran Neurological Clinic may call me and, if necessary, leave messages on my answering machine.

Patient Information:

_____ By initialing, I acknowledge that I have received the Notice of Privacy Practices of the Noran Neurological Clinic/Minnesota Diagnostic Center.

I understand all of the above and I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at anytime and that my revocation shall have no effect on any actions taken prior to my revocation.

Patient's Name (please print)

Date of Birth

Signature of Patient or Personal Representative

Date

Relationship to Patient (if patient unable to sign)

NAME _____ DOB: _____

Insurance Coverage Information

Motor Vehicle Insurance Information

Minnesota is a no-fault state. All claims go through the patient's auto insurance regardless of fault.

Motor vehicle insurance carrier: _____

Date of injury: _____ Claim number: _____

Claims address: _____

Policy number: (only needed if claim number is not available): _____

Name and phone of the adjuster assigned: _____

Are you being treated for a motor vehicle related condition?.....Yes ___ No ___

If yes, has your case been settled?.....Yes ___ No ___

Is your case being denied?.....Yes ___ No ___

Do you have an attorney?.....Yes ___ No ___

Attorney's Name: _____ **Attorney's Phone Number:** _____

Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Worker Compensation Insurance Information

Name of Employer at time of injury: _____

Workers Comp insurance carrier: _____

Date of injury: _____ Nature of injury: _____

Claim number: _____

Claims address: _____

Name and phone of adjuster assigned to claim or contact at employer: _____

Are you being treated for a work related injury or condition?.....Yes ___ No ___

If yes, has your case been settled?.....Yes ___ No ___

Is your case being denied?.....Yes ___ No ___

Was a Motor Vehicle involved in the injury?.....Yes ___ No ___

Do you have an attorney?.....Yes ___ No ___

Attorney's Name: _____ **Attorney's Phone Number:** _____

Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Other Injury Information

Insurance carrier covering injury: _____

Date of injury: _____ Nature of injury: _____

Claim number: _____

Claims address: _____

Do you have an attorney?.....Yes ___ No ___

Attorney's name: _____ **Attorney's phone number:** _____

Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Health Insurance

Primary Insurance information-

Name of insurance: _____ Insurance ph# _____ Effective date: _____

Policy number: _____ Group or account number: _____

Subscriber's name: _____ Subscribers date of birth: _____

Secondary Insurance information-

Name of insurance: _____ Insurance ph# _____ Effective date: _____

Policy number: _____ Group or account number: _____

Subscriber's name: _____ Subscribers date of birth: _____