

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.

PATIENT INFORMATION-PEDIATRIC NEUROLOGY CONSULTATION

This detailed **(confidential)** information will help your doctor identify areas of concern for your child. Some sections may not apply to your child, but please complete as many sections as possible. This information will be considered a confidential part of the medical record.

Name: _____ **Date of Birth:** _____
Account Number: _____ **Provider:** _____ **Today's Date** _____

Age: _____ Handedness Right Left Not established yet

School Grade: _____ School Name: _____

Pediatrician or family doctor: _____

Birth and pregnancy history:

Birth weight: _____ Born at _____ weeks of pregnancy _____ vaginal _____ c-section

Apgar scores (if known): _____ Planned _____ Surprise

Were fertility treatments used? No Yes IVF

Mother's pregnancy history: Number births _____ Number miscarriages _____

Medications during pregnancy: None

Prenatal vitamins, started at _____ weeks

Other _____

Please check all that apply to your child's pregnancy:

Fever or infection in the mother High blood pressure Pre-eclampsia

Diabetes Vaginal bleeding Smoking

Alcohol use Vomiting requiring medical treatment

Other complication: _____

Nursery stay: 3 days or less more than 3 days – How long? _____

Developmental history:

Rolled over at _____

Sat at _____

Crawled at _____

Walked independently at _____ Not yet

First word with meaning, without prompting at _____ Not yet

Combined 2 words at _____ Not yet

Toilet trained at _____ Not yet

Has your child ever had loss of speech or developmental skills? no yes

Does your child receive: Physical therapy? no yes How often? _____

Occupational therapy? no yes How often? _____

Speech therapy? no yes How often? _____

Current Medications: Please list any medications your child takes, including vitamins or supplements.

Name: _____ Dose: _____

Does your child have a medication allergy? yes no

Please list any medication allergies: _____

Please list any alternative, chiropractic, or supplemental therapies: _____

Medication history:

What medications has your child tried previously for the condition that brings you to the neurologist today?

Medication: _____ Maximum dosage: _____ When, and for how long? _____

Example: Depakote 500 mg twice daily November 2007 to May 2008

Past medical history:

- Ear infections None Rarely Many
- Asthma
- Headaches
- Seizures With Fever Without Fever
- Breath-Holding Spells
- Passing out (syncope) When? _____
- Meningitis
- Encephalitis
- Head Injuries
- Measles
- Chicken Pox
- Dehydration (Diarrhea)
- Allergies
- ADHD or ADD
- Learning disabilities
- Behavioral disabilities

Immunizations:

- Up to Date
- Adverse reaction to immunization? Yes No
- If yes, please describe Reaction: _____
- _____
- _____

Previous Hospitalizations:

Previous Surgeries (include dates) None Ear Tubes _____ Tonsils

Other: _____

Academic Performance:

- Typical grades: As Bs Cs Ds Failing
- Best subjects: _____
- Areas of difficulty: _____
- Recent worsening of school performance: no yes
- Special education services, IEP, EBD, or chapter/title services? no yes
- Sports/activities: _____
- _____

Psychosocial

Parents are: Married Never Married Live together Divorced Separated

If divorced

Both parents involved: Yes No Share Custody Maternal Custody Paternal Custody

- Does child attend daycare? no yes, licensed yes, unlicensed
- Any smokers in the household? no yes, indoors yes, outdoors only
- Is anyone abusing your child physically, emotionally, or sexually? no yes
- Has your child been abused in the past? no yes
- Does your child have problems making and maintaining eye contact? no yes
- Does your child have problems in school? no yes
- Does your child interact well with other children? no yes

Family history:

Some genetic and acquired conditions are associated with ethnic origin and occupational factors. Please specify for example whether they were English, Danish, French, Swiss, Eastern European, Mexican, etc.

Parents	Age	Health condition	Occupation	Ethnicity	Lives at Home
Biologic father	_____	_____	_____	_____	___no ___yes
Biologic mother	_____	_____	_____	_____	___no ___yes
Brother (s)	_____	_____	_____	_____	___no ___yes
	_____	_____	_____	_____	___no ___yes
Sister(s)	_____	_____	_____	_____	___no ___yes
	_____	_____	_____	_____	___no ___yes
	_____	_____	_____	_____	___no ___yes

Has any relative (biologic relative to the patient) had any of the following difficulties?

- Seizures _____no ___yes Who? _____
- Headaches _____no ___yes Who? _____
- Muscle disease _____no ___yes Who? _____
- Cognitive disability _____no ___yes Who? _____
- Mental retardation _____no ___yes Who? _____
- Autism _____no ___yes Who? _____
- ADD/ADHD _____no ___yes Who? _____
- Learning disability _____no ___yes Who? _____
- Tics _____no ___yes Who? _____
- Depression, anxiety _____no ___yes Who? _____
- Bipolar, manic/depressive _____no ___yes Who? _____
- Schizophrenia _____no ___yes Who? _____
- Brain tumor _____no ___yes Who? _____
- Multiple sclerosis _____no ___yes Who? _____
- Aneurysm _____no ___yes Who? _____
- Stroke under age 50 _____no ___yes Who? _____
- Heart attack under age 50 _____no ___yes Who? _____
- Multiple miscarriages _____no ___yes Who? _____
- Blood clotting disorder _____no ___yes Who? _____
- Death of baby or small child _____no ___yes Who? _____
- Other _____

System Review:

Please mark any of the following that apply to your child:

- ___ Headaches
- ___ Seizures
- ___ Dizziness
- ___ Vision changes
- ___ Hearing difficulty
- ___ Fainting
- ___ Trouble walking
- ___ Muscle weakness
- ___ Neck or back pain
- ___ Urination
- ___ Constipation
- ___ Diarrhea
- ___ Seems depressed
- ___ Seems anxious
- ___ Abnormal movements
- ___ Heart palpitations
- ___ Excessive thirst
- ___ Feeling excessively cold
- ___ Rash
- ___ Excessive fatigue
- ___ Excessive sleepiness
- ___ Snoring
- ___ Easy bruising
- ___ Difficulty sleeping
- ___ Abdominal pain
- ___ Skin or hair changes
- ___ Unexpected weight gain or loss
- ___ Not able to sweat
- ___ Appetite changes
- ___ Inability to play in hot weather

Other: _____

When was vision last checked? _____ ___never

When was hearing last checked? _____ ___never

**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: _____