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. We request that all minors be accompanied by a parent or guardian at their appointment. 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. We will also be collecting any copays that apply to that day's visit. We accept Visa, MasterCard, Discover, American Express, cash, or checks. 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
					___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
___Vision changes
___Trouble walking
___Urination
___Seems depressed
___Heart palpitations
___Rash
___Snoring
___Abdominal pain
___Not able to sweat
___Seizures
___Hearing difficulty
___Muscle weakness
___Constipation
___Seems anxious
___Excessive thirst
___Excessive fatigue
___Easy bruising
___Skin or hair changes
___Appetite changes
___Dizziness
___Fainting
___Neck or back pain
___Diarrhea
___Abnormal movements
___Feeling excessively cold
___Excessive sleepiness
___Difficulty sleeping
___Unexpected weight gain or loss
___Inability to play in hot weather

Other: ________________________________

When was vision last checked? ____________________ ___never

When was hearing last checked? ____________________ ___never

NORAN NEUROLOGICAL CLINIC, P.A.
MINNESOTA DIAGNOSTIC CENTER

Acknowledgement of Receipt of Notice of Privacy Practices. (Please see our website for a copy of our Notice of Privacy Practices).

Patient Name:
Date of Birth:

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of the Noran Neurological Clinic, P.A. /Minnesota Diagnostic Center.

______________________________ ______________
Signature of Patient or Personal Representative Date

____
Print Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

CONTACT INFORMATION:

The contact information of the patient or personal representative who signed this form should be filled in below.

Address:

Telephone:

______________ (daytime)
______________ (evening)

The Patient or Personal Representative noted above was provided the Notice of Privacy Practices and this Acknowledgement Form and did not sign the Acknowledgement Form.

Reason for not signing:

______________________________ ______________
Name Date

____
Position

NAME: ____ **DOB:**_________________________

GENERAL RELEASE OF INFORMATION:

I authorize Noran Neurological Clinic on behalf of myself and/or dependents to furnish medical records, including films and billing information to my insurance company, HMO or other third-party payer as may be necessary for the payment of a bill, determination of benefits or for utilization and quality review purposes.

I further authorize the release of this information to healthcare facilities that Noran Clinic may refer me to for continuing medical care, such as clinics, labs, therapy facilities, and other providers. I understand I am financially responsible for any balance not paid by my insurance and considered the responsibility of the patient. I hereby authorize payment of medical benefits to Noran Neurological Clinic for services provided to myself and/or dependents.

If not previously revoked, this authorization will terminate in one year.

Appointment Reminders and other health-related services:

We may use and disclose medical information to contact you in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to you. We may call you and, if necessary, leave messages on your answering machine. We may send you a notice if you missed your scheduled appointment asking you to contact us to reschedule.

Insurance company: ____

Signature of patient or responsible party ____________________________ Date: _________

If patient unable to sign...

Reason patient unable to sign: _______________________ *Relationship to patient* ______________________

MEDICARE LIFETIME CONSENT/AUTHORIZATION

I request payment of authorized Medicare benefits be made either to me or on my behalf to Noran Neurological Clinic for any services furnished to me by physician/clinic/ supervisor. I authorize any holder of hospital or medical information about me and/or any information needed to determine benefits payable for related services to be released to the Health Care Financing Administration and its agents. I permit a copy of this authorization to be used in place of the original.

MEDICARE ID#: ____________________ **SIGNATURE:** _________________________________

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: ________________

Medication Education For Patients

The Noran Clinic strives to provide quality health care to our patients. We have outlined some general guidelines and helpful hints for you to refer to when you are on medication or refilling your prescription.

General Guidelines

Tell your physician about all medications you are taking, including non-prescription products such as dietary supplements, vitamins, herbal remedies, Tylenol, aspirin and other over the counter medications.

Tell your physician about any allergies you have or bad reactions you have had to medications in the past.

Do not stop medications without discussing it with your physician. Some medications require that you reduce the dose gradually as stopping abruptly may be harmful or cause other symptoms.

Take your medication exactly as your doctor prescribes. Take it only for the condition for which is prescribed.

Don't adjust your dose because of your size or how you feel. Consult your doctor before making any changes in how you take your medication.

Any medication can have any side effect. If you think you are experiencing an adverse or allergic reaction to the medication call your doctor immediately, or the Emergency Room if necessary.

Do not give your prescribed medication to family members or anyone else. Medication prescribed for you may not be appropriate for someone else and may be harmful.

Check the expiration date on medications you have at home. Read the labels on all prescription and over the counter medications, and discard anything that is past its expiration date. Throw out any old or damaged medication containers.

Keep all medication out of the reach of children!

Prescription Refills

The pharmacy and clinic work together, please call your pharmacy to request your refill (even if the bottle states no more refills).

Allow 24-48 hour notice for a refill request. Call during office hours 8am to 4:30pm, Monday through Friday.

The pharmacist may need the refill number from the label on the medication. Have your prescription bottle available when calling your pharmacy.

Refills will only be authorized during regular office hours. Our doctors cannot refill some medications when the clinic is closed. This is especially true with narcotics or controlled drugs.

There are certain medications that require written authorization and cannot be called to the pharmacy. For refills on these medications you must call our clinic during regular office hours. The written prescription can be mailed to you or picked up during clinic hours. Clinic hours are 8am to 5pm, Monday through Friday.