



Patient Registration

Patient: _____ Social Security #: _____
Date of Birth: _____ Sex: _____
Address: _____ City: _____ Zip: _____
Email: _____
Race: _____ Ethnicity: _____

Mother/Guardian: _____
Primary Phone: _____ Secondary Phone: _____

Father/Guardian: _____
Primary Phone: _____ Secondary Phone: _____

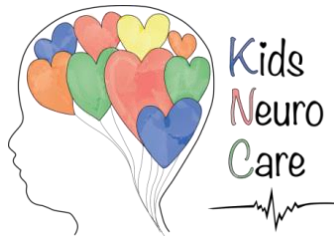
Insurance Company: _____
Address: _____ City: _____ Zip: _____
Member ID: _____ Phone: _____

Primary Care/Referring Physician: _____
Address: _____ City: _____ Zip: _____
Phone: _____ Practice Name: _____

Pharmacy: _____ Phone: _____

Parent/Guardian Signature: _____ **Date:** _____

If a parent or guardian cannot bring the patient to the appointment, a signed letter stating the name of the person bringing the patient and that person's valid ID must be presented at check-in.



Office Policies and Procedures

Cancellations/No Shows: We will not make appointments for patients who excessively cancel/no show to appointments. **You must call our office 24 hours prior to your appointment to reschedule or the FOLLOWING FEES WILL APPLY:**

AMB EEG No-Show Fee:	\$100.00	Office Visit No-Show Fee:	\$30.00
LTM EEG No-Show Fee:	\$100.00	EEG No-Show Fee:	\$75.00

Payment for Denied Services: You will be responsible for payment of services that are **NOT** covered by your insurance. Furthermore, it is your responsibility to notify our office prior to your appointment if your insurance plan has changed. It is also your responsibility to request and obtain referrals/authorizations through your PCP if required by your insurance carrier.

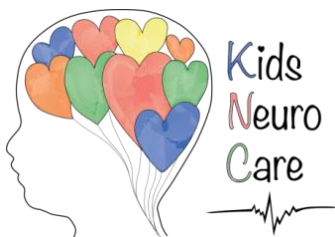
Payment for Services: Your copayment and any prior balance is due at the time of service unless otherwise prearranged prior to the appointment.

Medical Records: Medical Records such as EEG's, Labs, MRI's and other test results can be provided for a fee of \$1.00 per page. Forms requested for the Doctor to fill out will be a \$15.00 flat fee. You will need to fill out a Medical Release form provided by Kids Neuro Care for any and all other records to be forwarded to other Physicians, Attorneys, School etc.

Prescriptions: Bring a list of current medications including dosing and frequency being given to the patient to the appointment and request any prescription refills needed during the appointment. If a refill is needed before the next appointment, call the office during business hours. If your child has not been seen in our office within the past three months, we will **NOT** fill prescriptions without a return visit appointment being scheduled. At appointments, the patient's prescription will be filled to last until the next scheduled appointment.

Parent/Guardian Name: _____ **Patient:** _____

Parent/Guardian Signature: _____ **Date:** _____



Your Signature Will Serve as Consent for the Following

Consent: I, hereby, give consent for Kids Neuro Care to provide the necessary treatment discussed. I authorize use of information to coordinate and manage my child's healthcare and receive payment for services.

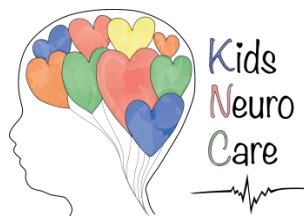
Insurance: I understand it is my responsibility to know my insurance coverage and benefits including contracted laboratories and hospitals where my child may receive care. It is my responsibility to provide the office with the necessary information to file claims and to notify the office of any insurance coverage changes prior to visits. I authorize payment of medical benefits directly to Kids Neuro Care for services rendered.

Mail: Kids Neuro Care may send me mail or email that assists the practice in carrying out treatment, payment, and healthcare operations such as appointment reminders, patient statements, and school forms.

Medical Release: I authorize any holder of medical records for my child to release to Kids Neuro Care, independent laboratories, and insurance carriers information needed for treatment, claims processing, and payments. I permit a copy of this authorization to be used in place of the original.

Parent/Guardian Name: _____ Patient: _____

Parent/Guardian Signature: _____ Date: _____



New Patient Medical History Questionnaire

Child's Name: _____ D.O.B: _____

Help us to get to know your child better, please answer these questions to the best of your ability.

Main Reason(s) for Visit: _____

Past Medical History

Medication Allergies	
Serious Illness/Surgeries	
Head injuries	
Hospitalizations	

Birth History

Were any of the following concerns during pregnancy?

No problems
 Abnormal Bleeding
 High Blood Pressure
 Early Labor
 Diabetes
 Tobacco use
 Alcohol/substance use
 Trauma

Birth weight ___ lbs ___ oz	Vaginal ___ C-section ___
Born early or late? _____ weeks	Discharged home in 2-3 days ___Y ___N
Problems during delivery? ___Y ___N	Newborn Jaundice ___Y ___N

Developmental History

Any worries about abnormal or slow development	___Yes ___No
Has your child ever lost developmental skills?	___Yes ___No
Has the child received any therapy for developmental delays?	___Yes ___No
Does your child receive special classroom modifications?	___Yes ___No Current Grade _____

Family History

Has anybody in the family any of the following conditions:

___Epilepsy/Seizures	___Autism	___Migraines	___Brain tumor	___Aneurysm
___Multiple Sclerosis	___Muscle/nerve disorder	___Birth Defects	___Bleeding Disorder	___Neurofibromatosis
___Learning Disability	___Tics/Tourette	___Stroke	___Psychiatric Disorder	___ADD/ADHD

Current Mediations

Review of Systems (Please indicate if any of these are problems for your child)

Confusion Y / N	Headaches Y / N	Dizziness Y / N	Blurred Vision Y / N
Numb/Tingling Y / N	Double Vision Y / N	Nausea/Vomiting Y/N	Ringling in ears Y/ N
Poor balance Y/N	Trouble walking Y / N	Stiffness Y / N	Drooling Y / N
Weakness Y / N	Clumsiness Y / N	Swallowing issues Y/N	Speech Difficulty Y/N
Seizures/Convulsions Y/N	Memory Problems Y/N	Mood Changes Y / N	Unable to sleep Y / N
Altered taste/smell Y/N	Change in appetite Y/N	Weight Loss/Gain Y/N	Excessive sleepiness Y/N
Fatigue Y / N	Nose bleeds Y / N	Fainting Spells Y / N	Involuntary Movements Y/N
Staring Spells Y / N	Loss of control bladder or bowel Y / N	Frequent belly pains Y/N	Chronic diarrhea or constipation Y / N
Low Back pain Y / N	Neck Pain Y / N	Joint pain/swelling Y/N	Tremors Y / N
Anxiety Y / N	Depression Y/ N	Disruptive behavior Y/N	Poor attention in school Y / N