Child and Adolescent Neurology Consultants
Patient Registration Form

Patient Name: _____ Male: ____ Female: ____

Date of Birth: _____ Patient's Race: _____ Patient's Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Patient Address: _____

City, State, ZIP: _____

Mobile Phone: _____ Secondary Phone: _____

E-mail Address: _____

Primary Language: _____ Does the patient need an interpreter? ☐ Yes ☐ No

Parent/Responsible Party: _____

Driver's Lic. # of Responsible Party: _____

Address, If Different Than Patient: _____

_____

Marital Status of Parents: _____

Custodial Parent(s): (If divorced, please provide proof of custody) _____

Legal Guardian (If other than parents, please provide proof of guardianship) _____

Referring / Primary MD: _____ Phone: _____

Preferred Pharmacy: _____ Location: _____

Parent/Responsible Party Information

Employer: _____

Primary Insurance	Secondary Insurance

Consent for Treatment: I authorize all medical or surgical procedure, test or treatment ordered by Dr. Shailesh M. Asaikar.

Release of Information: I authorize the release of medical information to my referring physician, insurance company, and/or legal guardian.

Assignment of Benefits: If my child is covered by and acceptable insurance, I authorize benefits to be paid directly to Dr. Shailesh M. Asaikar.

I/We give Child and Adolescent Neurology Consultants permission to leave confidential information on the following mobile phone number _____ and email _____.

By signing below, I agree to all terms and conditions stated above, including the attached **Financial Policy Agreement for Child and Adolescent Neurology Clinics.**

Parent/Responsible Party Signature **Date**

Shailesh M. Asaikar, MD

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Phone: (916) 649-9800
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Child and Adolescent Neurology Consultants
Child Neurology Database

Height: _____ Age: _____

Childs Name: _____ Date: _____ Weight: _____

Name of Person Completing Form: _____ Relationship: _____

Please answer all the questions to the best of your ability to assist us in evaluating your child's past medical history. Check YES or NO where appropriate. If not sure, leave blank.

1) Present history (What medical concerns can we help you with today?) _____

_____

_____

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Present Medications: _____

_____

2) Past Medical history (List of past surgeries and hospitalizations) _____

_____

Have you ever seen a neurologist in the past? ☐ Yes/No ☐ Who and when? _____ Where? ☐ Sutter ☐ UC Davis

Have you had an ☐ MRI, ☐ EEG or ☐ CT? When? _____

Are you Allergic? ☐ Yes/No ☐ List Medications Allergic to: _____

Please check if your child has had any of the following in the past:

☐ Meningitis	☐ Head injury	☐ Sleep disturbance	☐ Drug use
☐ Convulsions	☐ Knocked out	☐ School problems	☐ Bladder problems
☐ Epilepsy	☐ Weakness	☐ Unconsciousness	☐ Sexually active
☐ Alcohol use	☐ Bowel Problems	☐ Headaches	

3) Family History: (Check Where Appropriate)

Is there any ataxia incoordination?	☐ Yes/No ☐	Is there any blindness?	☐ Yes/No ☐
Is there any cerebral palsy?	☐ Yes/No ☐	Is there any muscle weakness or problems?	☐ Yes/No ☐
Is there any movement disorder?	☐ Yes/No ☐	Is there any intellectual disability?	☐ Yes/No ☐
Is there any dementia?	☐ Yes/No ☐	Are there seizures in the family?	☐ Yes/No ☐
Is there any deafness?	☐ Yes/No ☐	Is there any learning disability?	☐ Yes/No ☐
Is there any autism?	☐ Yes/No ☐		

If any answers are Yes, who and what relationship? _____

4) School: What school does the child attend? _____

Which grade is the child in? ___ What is the name of the teacher? _____

Briefly give impression of school behavior: _____

_____

Has your child had any psychological or speech evaluation? ☐ Yes/No ☐ Date _____

Does the child receive any special help at school? _____

Briefly describe any major problem which needs special attention: _____

_____

_____

What is the relationship between school personnel and the child's parents? (cordial, confrontational) _____

_____

_____

Please indicate the problems areas of learning (check):

☐ Relationship to authority ☐ Behavior ☐ Reading ☐ Achievement
☐ Speech ☐ Motivation ☐ Attention ☐ Relationship with peers
☐ Motor coordination ■ Eyesight

5) Social History:

Who lives at home? _____

What is your impression of the home environment? _____

6) Birth History:

Date of birth _____ Place of birth, name of hospital _____ Birth weight _____

Was the pregnancy normal? ☐ Yes/No ☐ Was the pregnancy full term? ☐ Yes/No ☐ Length of labor _____

Was the delivery normal? ☐ Yes/No ☐ Did the baby have trouble breathing? ☐ Yes/No ☐ Complications _____

7) Milestones Is development normal? Skip if your child is 5 years or older. (Check what your child does if applicable)

☐ Lifts head up while prone ☐ Follows with eyes/head over 90° ☐ Smiles responsively ☐ Lifts head above body
☐ Turns head to objects ☐ Fixes on, follows objects ☐ Smiles and vocalizes ☐ Holds head steady sitting
☐ Brings objects to mouth ☐ Turns in direction of sound ☐ Lifts head while supine ☐ Rolls from prone to supine
☐ Moves objects from hand to hand ☐ Babbles ☐ Sits in tripod fashion ☐ Stands with support
☐ Reaches out for people ☐ Says dada, baba ☐ Sits well without support ☐ Stands up holding
☐ Waves bye-bye ☐ Uses pincer grasp ☐ Uses words with meaning ☐ Understands simple commands
☐ Walks by self, falls easily ☐ Says several words ☐ Scribbles with crayons ☐ Points to things wanted
☐ Drinks from a cup ☐ Climbs stairs alone ☐ Throws ball ☐ Builds small block tower
☐ Feeds self ☐ Takes off clothes ☐ Points to body parts ☐ Uses words intelligibly
☐ Runs up and down stairs ☐ Speaks 2-3 word sentences ☐ Turns single book pages ☐ Builds large block tower
☐ Kicks ball ☐ Uses "you", "me" ☐ Walks on tiptoes ☐ Uses phrases
☐ Knows full name ☐ Recognizes three colors ☐ Jumps and plays ☐ Stands on one foot
☐ Pedals tricycle ☐ Draws vertical lines ☐ Copies circle ☐ Recites nursery rhymes

8) Review of systems (Check where appropriate) Do you have problems with:

☐ Headaches? ☐ Bleeding troubles? ☐ Chest pain? ☐ Bowel movements?
☐ Seizures? ☐ Numbness? ☐ Smell or taste? ☐ Easy bruising?
☐ Abnormal heartbeats? ☐ Bladder troubles? ☐ Weakness? ☐ Dizziness?
☐ Vision? ☐ Breathing? ☐ Stomach troubles? ☐ Skin troubles?
☐ Swallowing? ☐ Sleep? ☐ Hearing? ☐ Asthma?
☐ Weight? ☐ Blackouts? ☐ Appetite? ☐ Balance?
☐ Anxiety? ☐ Depression?

9) Patient Comments (any additional comments) _____

Child and Adolescent Neurology Consultants
Payment Policies

Health and accident policies are an arrangement between you and your insurance company. We bill your insurance as a courtesy to you. It is the patient's responsibility (or the parent if the patient is a minor) to know the requirements of your particular insurance policy and the facilities that they are allowed to use in order to receive the best possible benefits.

The patient is responsible for any co-payments and/or deductibles including services not covered by your insurance plan. as well as the amounts the insurance carrier denies as the patient's responsibility.

Please be prepared to pay for plan co-payments at the time of service, otherwise the following fees will apply:

- **A $10.00 administrative billing fee for non-payment of co-pays and cash only visits.**
- **A $25.00 non-cancellation fee will apply for appointments not cancelled within 24 hours of the scheduled appointment date.**

Child's Name: _____

Parent Signature: _____

Date: _____