

Child and Adolescent Neurology Consultants Patient Registration Form

Patient Name: _____ Male: _____ Female: _____
Date of Birth: _____ Patient's Race: _____ Patient's Ethnicity: Hispanic
Patient Address: _____ Non-Hispanic
City, State, ZIP: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Pager No: _____
E-mail Address: _____
Primary Language: _____ Does the patient need an interpreter? Yes No
Parent/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: _____
Driver's License #: _____
Emergency Contact: _____
Address and Phone #: _____

Primary Insurance

Secondary Insurance

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

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/Dr. Paul M. Chretien/Dr. Virginia Lee.

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
Paul M. Chretien, MD
Virginia Lee, MD
1111 Exposition Blvd.,
Bldg. 700, Suite 102
Sacramento, CA 95815
Phone: (916) 649-9800
Fax: (916) 649-9801

Child and Adolescent Neurology Consultants
Child Neurology Database

1/2

Height: _____ Age: _____

Date: _____ Weight: _____

Childs Name: _____

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:

- | | | | |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Head injury | <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Knocked out | <input type="checkbox"/> School problems | <input type="checkbox"/> Bladder problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Weakness | <input type="checkbox"/> Unconsciousness | <input type="checkbox"/> Sexually active |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Headaches | |

3) Family History: (Check Where Appropriate)

- | | | | |
|-------------------------------------|--|---|--|
| Is there any ataxia incoordination? | <input type="checkbox"/> Yes/No <input type="checkbox"/> | Is there any blindness? | <input type="checkbox"/> Yes/No <input type="checkbox"/> |
| Is there any cerebral palsy? | <input type="checkbox"/> Yes/No <input type="checkbox"/> | Is there any muscle weakness or problems? | <input type="checkbox"/> Yes/No <input type="checkbox"/> |
| Is there any movement disorder? | <input type="checkbox"/> Yes/No <input type="checkbox"/> | Is there any intellectual disability? | <input type="checkbox"/> Yes/No <input type="checkbox"/> |
| Is there any dementia? | <input type="checkbox"/> Yes/No <input type="checkbox"/> | Are there seizures in the family? | <input type="checkbox"/> Yes/No <input type="checkbox"/> |
| Is there any deafness? | <input type="checkbox"/> Yes/No <input type="checkbox"/> | Is there any learning disability? | <input type="checkbox"/> Yes/No <input type="checkbox"/> |
| Is there any autism? | <input type="checkbox"/> Yes/No <input type="checkbox"/> | | |

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) _____

Name: _____

Please indicate the problems areas of learning (check):

- | | | | |
|--|-------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Relationship to authority | <input type="checkbox"/> Behavior | <input type="checkbox"/> Reading | <input type="checkbox"/> Achievement |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Motivation | <input type="checkbox"/> Attention | <input type="checkbox"/> Relationship with peers |
| <input type="checkbox"/> Motor coordination | <input type="checkbox"/> 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)

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

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

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Headaches? | <input type="checkbox"/> Bleeding troubles? | <input type="checkbox"/> Chest pain? | <input type="checkbox"/> Bowel movements? |
| <input type="checkbox"/> Seizures? | <input type="checkbox"/> Numbness? | <input type="checkbox"/> Smell or taste? | <input type="checkbox"/> Easy bruising? |
| <input type="checkbox"/> Abnormal heartbeats? | <input type="checkbox"/> Bladder troubles? | <input type="checkbox"/> Weakness? | <input type="checkbox"/> Dizziness? |
| <input type="checkbox"/> Vision? | <input type="checkbox"/> Breathing? | <input type="checkbox"/> Stomach troubles? | <input type="checkbox"/> Skin troubles? |
| <input type="checkbox"/> Swallowing? | <input type="checkbox"/> Sleep? | <input type="checkbox"/> Hearing? | <input type="checkbox"/> Asthma? |
| <input type="checkbox"/> Weight? | <input type="checkbox"/> Blackouts? | <input type="checkbox"/> Appetite? | <input type="checkbox"/> Balance? |
| <input type="checkbox"/> Anxiety? | <input type="checkbox"/> 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: _____