

# Northwest Houston Neurology, PA

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## THIS SECTION REFERS TO THE PATIENT ONLY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Sex \_\_\_ D.O.B. \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_ DL# \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Home Ph# \_\_\_\_\_ Work Ph# \_\_\_\_\_ Cell Ph# \_\_\_\_\_

Email address \_\_\_\_\_ Preferred method of contact \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Employer Ph# \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Language \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation to patient \_\_\_\_\_ Ph# \_\_\_\_\_

## If a MINOR, complete with PARENT'S info – If MARRIED, complete with SPOUSE'S info

**Mother's/Spouse's Name** \_\_\_\_\_ D.O.B. \_\_\_\_\_

SS# \_\_\_\_\_ DL# \_\_\_\_\_ Email Address \_\_\_\_\_

Address (if different than above) \_\_\_\_\_ Ph# \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Ph# \_\_\_\_\_

**Father's Name** \_\_\_\_\_ D.O.B. \_\_\_\_\_

SS# \_\_\_\_\_ DL# \_\_\_\_\_ Email Address \_\_\_\_\_

Address (if different than above) \_\_\_\_\_ Ph# \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Ph# \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company \_\_\_\_\_ Customer Service # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Employer \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Subscriber Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

## ADDITIONAL INFORMATION

Name and Phone Number of Referring Provider \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Pharmacy Ph# or Address \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Name of family members that are also patients here \_\_\_\_\_

I, the insured person for this account, do assign the collection of benefits to the Pediatric and Adolescent Center of NW Houston, PA, Northwest Houston Neurology, PA. I give my permission to release medical information needed to process medical claims. I understand that the Pediatric and Adolescent Center of NW Houston, PA and the Northwest Houston Neurology, PA will attempt to collect payment from my insurance company, yet I am ultimately responsible for the payments on this account. Any balance unpaid by my insurance company after 60 days of filing can be billed to me for payment. I have been provided a copy of the office policies.

**Signature of Patient/Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

# Northwest Houston Neurology, PA

## Office Policy

Our goal is to provide quality medical care and to maintain a positive patient-physician relationship. Providing you with our office policy in advance encourages the flow of communication and enables us to achieve our goal. Please review our policy carefully.

### Appointments

- All patients must complete the patient information forms prior to seeing the physician. We will require copies of your insurance card and photo identification. You may be asked to update this information annually.
- If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule your appointment.
- We value the time we have set aside to spend with you. If you are unable to keep an appointment, please provide a 24 hour notice so that we may offer this time to another patient. If you do not provide notice, you will be charged a No Show Fee. Failure to comply with our cancellation policy can lead to dismissal from the practice.

### Financial Policy

- Payment in full is due at the time services are rendered, including past due balances.
  - Any patient share estimates (copayments, deductibles, co-insurances) are due in full at the time of service. An estimate is only an estimate and never a guarantee of exact fees. Your final share will be determined once the insurance processes the claims.
    - Patient overpayments will be refunded within 30 days of the request.
  - Our office verifies insurance coverage as a courtesy; however, payment is not guaranteed claims are processed by the insurance company. It is the insured's responsibility to understand the benefit plan with regards to covered services and participating facilities. The patient will be billed directly for any services not covered by insurance.
  - If our office is unable to verify the insurance coverage, the patient is financially responsible for the visit.
  - It is your responsibility to update us with current insurance information. If the insurance company you designate is incorrect, you may be held responsible for charges due to timely filing requirements.
  - If the insurance company requires a referral and one is not on file, the patient is financially responsible for the visit.
  - We are happy to help assist with insurance questions. However, specific coverage issues or claims processing questions should be directed directly to your insurance company.
- We do not file claims to the following (see below). The patient is responsible for payment in full. We will provide receipts so that you may file claims for reimbursement.
  - Secondary Insurances (Medicare is an exception)
  - Worker's Compensation
  - Automobile Insurance
- Your insurance company may request that you supply information to them directly in order to process claims (i.e. coordination of benefits, pre-existing info.). It is your responsibility to comply in a timely manner.
- If the patient is a minor, in cases of divorce or separation, the person requesting services is responsible for the payment due at the time of service and for any past due balance.
- We accept cash, check, Visa, and MasterCard. A \$30 fee will be assessed for returned checks. Checks returned due to stop payment may lead to dismissal from the practice.
- Statement are sent out monthly and payment is appreciated within 10 days upon receipt. Accounts with balances over 90 days with no activity can be turned over to collections and dismissed from our practice.

### Authorizations / Prescriptions and Refills

- Some tests ordered by our physicians may require authorization from your insurance carrier. If this is the case, please allow 10 business days for our office to obtain the authorization.
  
- Prescriptions and Refills
  - **We do not dispense written prescriptions.** We will send prescriptions electronically or call in prescriptions directly to the pharmacy on file.
  - Controlled Substances
    - Controlled Substance prescriptions cannot be sent electronically to pharmacy; we will call in to pharmacy on file when applicable
    - Some Controlled Substances cannot be called in to the pharmacy and must be picked up by an authorized person over the age of 18.
    - These prescriptions require monthly or quarterly visits with the physician.

### Forms

- Forms will be completed during an appointment. Please bring forms to the visit and complete everything other than the section required by the physician. We reserve the right to decline completion of these types of forms.
  
- There is a \$25 fee for medical letters written by physicians.

### Transfer of Records

A \$25 fee will be assessed for a copy of your medical records. A release of information must be signed. If you transfer to another physician or we refer you to another physician, we will send that physician a copy of your last visit and pertinent records free of charge. Please allow 10 business days for transfer of records.

**Non Compliance with our office policy and violation of physician/patient relationship can lead to dismissal from the practice. Examples of this include noncompliance with physician orders, appointments, disruptive behavior, etc.**

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**Signature of Understanding:** I have read and understand the above stated office and financial policy.

Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_

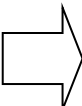
Name of Parent / Guardian if Patient under 18 \_\_\_\_\_ Relationship \_\_\_\_\_

 Patient or Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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### Assignment of Benefits

I, the undersigned, authorize payment of medical benefits to Northwest Houston Neurology, PA, for any services furnished to the patient by the practice. I also authorize you to release to my insurance company or their agent, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims benefits.

 Patient or Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# NW Houston Neurology PA

## CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The patient hereby consents to the use or disclosure of his/her individually identifiable health information (protected health information) by NW Houston Neurology PA in order to carry out treatment, payment, or health care operations. The patient should review NW Houston Neurology PA Notice of Privacy Practices for Protected Health information for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such Notice prior to signing this consent form.

NW Houston Neurology PA reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If NW Houston Neurology PA does change the terms of its Notice of Privacy Practices, the patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. NW Houston Neurology PA is not required to agree to such requested restrictions; however, if NW Houston Neurology PA does agree to Patient requested restriction(s), such restrictions are then binding on NW Houston Neurology PA.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to NW Houston Neurology PA in writing. The revocations shall be effective except to the extent that NW Houston Neurology PA has already taken action in reliance on the Consent.

NW Houston Neurology PA may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that NW Houston Neurology PA is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, NW Houston Neurology PA has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that NW Houston Neurology PA is required by law to treat individuals).

**I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT, OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.**

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient/Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Print Witness Name

# NW Houston Neurology, PA

## Patient Privacy Questionnaire (HIPAA)

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
DL Number

**This signed Privacy Form will remain in your file and considered current. If there are any changes, you must notify our office and complete another form.**

1. Please list other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Please list other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

You may be contacted by your office to remind you of any appointments, healthcare treatment options or other health services. We will limit the amount of information left in the message to just the information necessary to confirm the appointment or to request a return call.

3. Can confidential messages (i.e. appointment reminders, messages) be left on your voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

4. Please provide an email address we could send correspondence to. \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient/Guardian

\_\_\_\_\_  
Relationship to Patient

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Drug Allergies: \_\_\_\_\_ Assistive Devices: \_\_\_\_\_

**PAST MEDICAL HISTORY**

- Headache  Migraine  Stroke/ Mini Stroke  Seizure  Alzheimer's Disease  Tremor
- Parkinson's Disease  Depression  Anxiety  High Blood Pressure  Diabetes  Heart Disease
- Other \_\_\_\_\_

**PAST SURGICAL HISTORY** List ALL Surgeries \_\_\_\_\_

**FAMILY HISTORY**

- Headache  Migraine  Stroke/ Mini Stroke  Seizure  Alzheimer's Disease  Tremor
- Parkinson's Disease  Depression  Anxiety  High Blood Pressure  Diabetes  Heart Disease
- Other \_\_\_\_\_

**SOCIAL HISTORY** Occupation: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed  
Tobacco Use?  Yes  No, How Much \_\_\_\_\_ Drink Alcohol?  Yes  No, How Much \_\_\_\_\_

**This section is for CHILDREN ONLY. Only complete for patients under 18 years of age.**

**Pregnancy:**  Normal  Problems \_\_\_\_\_

**Delivery**  Normal  C Section  Problems \_\_\_\_\_

**Development:**  Sitting \_\_\_\_\_ Months,  Walking \_\_\_\_\_ Months,  Started Speaking \_\_\_\_\_ Months

**REVIEW OF SYMPTOMS** Please check ALL that apply

**GENERAL**

- Neck Pain
- Back Pain
- Weight Gain
- Weight Loss
- Fever

**HEAD/NECK**

- Head Injury
- Vision Problems
- Sore Throat
- Trouble Swallowing
- Hearing Problems

**CARDIOVASCULAR**

- Chest Pain
- Skipped/Irregular Heartbeat

**NEUROLOGIC**

- Dizziness
- Numbness / Tingling
- Weakness
- Headaches
- Seizure
- Passing out Spells
- Tremors

**RESPIRATORY**

- Shortness of Breath
- Sleep Apnea
- Cough
- Wheezing

**GASTROINTESTINAL**

- Abdominal Pain
- Vomiting / Diarrhea

**GENTOURINARY**

- Pain with Urination
- Unable to Urinate
- Involuntary Urination

**MUSCULOSKELETAL**

- Joint Swelling
- Joint Pain

**SKIN**

- Rash

**ALLERGIES**

- Nasal Allergies

**PSYCHIATRY**

- Anxiety
- Depression

**SLEEP**

- Awake with Dry Mouth
- Difficulty Concentrating
- Excessive Daytime Sleepiness
- Frequent Awakenings
- Loud Snoring
- Memory Loss
- Morning Headaches
- Need to move legs
- Nervous / Anxious
- Nocturia
- Poor School Performance
- Racing Thoughts
- Reflux at night
- Sleep Talking
- Sleep Walking
- Teeth Grinding
- Unrefreshing Sleep
- Witnessed Apnea

# The Epworth Sleepiness Scale

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Date: \_\_\_\_\_

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

## How Sleepy Are You?


How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

**Write down the number corresponding to your choice in the right hand column. Total your score below.**



Situation	Chance of Dozing <small>Indicate 0, 1, 2, or 3</small>
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

 Total Score: \_\_\_\_\_

## Sleep Evaluation Questionnaire

### Directions

Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

### CHILD'S INFORMATION

Child's name:	Child's gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Child's birthdate:	Child's age:		
Child's racial/ethnic background:	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Black/African-American	<input type="checkbox"/> Asian-American
	<input type="checkbox"/> Native-American	<input type="checkbox"/> Hispanic-Latino	<input type="checkbox"/> Multi-racial
	<input type="checkbox"/> Other		

What are your major concerns about your child's sleep?

What things have you tried to help your child's problem?



## SLEEP HISTORY

### Weekday Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period on weekdays (add daytime and nighttime sleep): \_\_\_\_\_ hours \_\_\_\_\_ minutes

The child's usual bedtime on weekday nights: \_\_\_\_\_:\_\_\_\_\_

The child's usual waketime on weekday mornings: \_\_\_\_\_:\_\_\_\_\_

### Weekend/Vacation Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period during weekends and vacations (add daytime and nighttime sleep): \_\_\_\_\_ hours \_\_\_\_\_ minutes

The child's usual bedtime on weekend/vacation nights: \_\_\_\_\_:\_\_\_\_\_

The child's usual waketime on weekend/vacation mornings: \_\_\_\_\_:\_\_\_\_\_

### Nap Schedule

Number of days each week child takes a nap:       0     1     2     3     4     5     6     7

If child naps, write in usual nap time(S):    Nap 1: \_\_\_\_\_:\_\_\_\_\_  a.m.  p.m. to \_\_\_\_\_:\_\_\_\_\_  a.m.  p.m.

Nap 2: \_\_\_\_\_:\_\_\_\_\_  a.m.  p.m. to \_\_\_\_\_:\_\_\_\_\_  a.m.  p.m.

### General Sleep

Does the child have a regular bedtime routine?       yes     no

Does the child have his/her own bedroom?       yes     no

Does the child have his/her own bed?       yes     no

Is a parent present when your child falls asleep?       yes     no

Child usually falls asleep in...  
 own room in own bed (alone)  
 parents' room in own bed  
 parents' room in parents' bed  
 sibling's room in own bed  
 sibling's room in sibling's bed

Child sleeps most of the night in...  
 own room in own bed (alone)  
 parents' room in own bed  
 parents' room in parents' bed  
 sibling's room in own bed  
 sibling's room in sibling's bed

Child usually wakes in the morning in...  
 own room in own bed (alone)  
 parents' room in own bed  
 parents' room in parents' bed  
 sibling's room in own bed  
 sibling's room in sibling's bed

Child is usually put to bed by:     Mother     Father     Both Parents     Self     Others

Write in the amount of time the child spends in his/her bedroom before going to sleep: \_\_\_\_\_ minutes

Child resists going to bed?       yes     no      **If yes, do you think this is a problem?**       yes     no

Child has difficulty falling asleep?       yes     no      **If yes, do you think this is a problem?**       yes     no

Child awakens during the night?       yes     no      **If yes, do you think this is a problem?**       yes     no

After nighttime awakening, child has difficulty falling back to sleep?	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>If yes</b> , do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
Child is difficult to awaken in the morning?	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>If yes</b> , do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
Child is a poor sleeper?	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>If yes</b> , do you think this is a problem?	<input type="checkbox"/> yes <input type="checkbox"/> no

<b>Current Sleep Symptoms</b>							
							<b>(f) do not know</b>
							<b>(e) always (6 to 7 nights/days a week)</b>
						<b>(d) often (3 to 5 nights/days a week)</b>	
					<b>(c) sometimes (1 to 2 nights/days a week)</b>		
				<b>(b) not often (less than 1 night/day a week)</b>			
			<b>(a) never (does not happen)</b>				
1.	Difficulty breathing when asleep	a	b	c	d	e	f
2.	Stops breathing during sleep	a	b	c	d	e	f
3.	Snores	a	b	c	d	e	f
4.	Restless sleep	a	b	c	d	e	f
5.	Sweating when sleeping	a	b	c	d	e	f
6.	Daytime sleepiness	a	b	c	d	e	f
7.	Poor appetite	a	b	c	d	e	f
8.	Nightmares	a	b	c	d	e	f
9.	Sleepwalking	a	b	c	d	e	f
10.	Sleepwalking	a	b	c	d	e	f
11.	Screaming in his/her sleep	a	b	c	d	e	f
12.	Kicks legs in sleep	a	b	c	d	e	f
13.	Wakes up at night	a	b	c	d	e	f
14.	Gets out of bed at night	a	b	c	d	e	f
15.	Trouble staying in his/her bed	a	b	c	d	e	f
16.	Resists going to bed at bedtime	a	b	c	d	e	f
17.	Grinds his/her teeth	a	b	c	d	e	f
18.	Uncomfortable feeling in his/her legs; creepy-crawly feeling	a	b	c	d	e	f
19.	Wets bed	a	b	c	d	e	f

Current Daytime Symptoms							
							(f) do not know
						(e) always (6 to 7 days a week)	
					(d) often (3 to 5 days a week)		
				(c) sometimes (1 to 2 days a week)			
			(b) not often (less than 1 day a week)				
		(a) never (does not happen)					
1.	Trouble getting up in the morning	a	b	c	d	e	f
2.	Falls asleep in school	a	b	c	d	e	f
3.	Naps after school	a	b	c	d	e	f
4.	Daytime sleepiness	a	b	c	d	e	f
5.	Feels weak or loses control of his/her muscles with strong emotions	a	b	c	d	e	f
6.	Reports unable to move when falling asleep or upon waking	a	b	c	d	e	f
7.	Sees frightening visual images before falling asleep or upon waking	a	b	c	d	e	f

PREGNANCY/ DELIVERY	
Pregnancy	<input type="checkbox"/> Normal <input type="checkbox"/> Difficult
Delivery	<input type="checkbox"/> Term <input type="checkbox"/> Pre-term <input type="checkbox"/> Post-term
Child's birthweight:	
Only child?	<input type="checkbox"/> Yes <input type="checkbox"/> No      If no, circle birth order: 1 <sup>st</sup> 2 <sup>nd</sup> 3 <sup>rd</sup> 4 <sup>th</sup> 5 <sup>th</sup> 6 <sup>th</sup> 7 <sup>th</sup>

## MEDICAL AND PSYCHIATRIC HISTORY

### PAST MEDICAL HISTORY

Frequent nasal congestion	<input type="checkbox"/> Yes	Age of diagnosis:	
Trouble breathing through his/her nose	<input type="checkbox"/> Yes	Age of diagnosis:	
Sinus problems	<input type="checkbox"/> Yes	Age of diagnosis:	
Chronic bronchitis or cough	<input type="checkbox"/> Yes	Age of diagnosis:	
Allergies	<input type="checkbox"/> Yes	Age of diagnosis:	Allergic to what:
Asthma	<input type="checkbox"/> Yes	Age of diagnosis:	
Frequent colds or flus	<input type="checkbox"/> Yes	Age of diagnosis:	
Frequent ear infections	<input type="checkbox"/> Yes	Age of diagnosis:	
Frequent strep throat infections	<input type="checkbox"/> Yes	Age of diagnosis:	
Difficulty swallowing	<input type="checkbox"/> Yes	Age of diagnosis:	
Acid reflux (gastroesophageal reflux)	<input type="checkbox"/> Yes	Age of diagnosis:	
Poor or delayed growth	<input type="checkbox"/> Yes	Age of diagnosis:	
Excessive weight	<input type="checkbox"/> Yes	Age of diagnosis:	
Hearing problems	<input type="checkbox"/> Yes	Age of diagnosis:	
Speech problems	<input type="checkbox"/> Yes	Age of diagnosis:	
Vision problems	<input type="checkbox"/> Yes	Age of diagnosis:	
Seizures/Epilepsy	<input type="checkbox"/> Yes	Age of diagnosis:	
Morning headaches	<input type="checkbox"/> Yes	Age of diagnosis:	
Cerebral palsy	<input type="checkbox"/> Yes	Age of diagnosis:	
Heart disease	<input type="checkbox"/> Yes	Age of diagnosis:	
High blood pressure	<input type="checkbox"/> Yes	Age of diagnosis:	
Sickle cell disease	<input type="checkbox"/> Yes	Age of diagnosis:	
Genetic disease	<input type="checkbox"/> Yes	Age of diagnosis:	
Chromosome problem (e.g., Down's)	<input type="checkbox"/> Yes	Age of diagnosis:	
Skeleton problem (e.g., dwarfism)	<input type="checkbox"/> Yes	Age of diagnosis:	
Cranofacial disorder (e.g., Pierre-Robin)	<input type="checkbox"/> Yes	Age of diagnosis:	
Thyroid problems	<input type="checkbox"/> Yes	Age of diagnosis:	
Eczema (itchy skin)	<input type="checkbox"/> Yes	Age of diagnosis:	
Pain	<input type="checkbox"/> Yes	Age of diagnosis:	

**PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY**

Autism	<input type="checkbox"/> Yes	Age of diagnosis:
Developmental delay	<input type="checkbox"/> Yes	Age of diagnosis:
Hyperactivity/ADHD	<input type="checkbox"/> Yes	Age of diagnosis:
Anxiety/Panic Attacks	<input type="checkbox"/> Yes	Age of diagnosis:
Obsessive Compulsive Disorder	<input type="checkbox"/> Yes	Age of diagnosis:
Depression	<input type="checkbox"/> Yes	Age of diagnosis:
Suicide	<input type="checkbox"/> Yes	Age of diagnosis:
Learning disability	<input type="checkbox"/> Yes	Age of diagnosis:
Drug use/abuse	<input type="checkbox"/> Yes	Age of diagnosis:
Behavioral disorder	<input type="checkbox"/> Yes	Age of diagnosis:
Psychiatric Admission	<input type="checkbox"/> Yes	Age of diagnosis:

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist.

**CURRENT MEDICAL HISTORY**

Please list any medications your child currently takes:

Medicine	Dose	How often?
1.		
2.		
3.		
4.		

**LONG-TERM MEDICAL PROBLEMS**

If your child has long-term medical problems, please list the three you think are most important.

- 1.
- 2.
- 3.

**SURGERIES/HOSPITALIZATIONS**

Has your child ever had his/her tonsils removed?  Yes      Age of surgery:

Has your child ever had his/her adenoids removed?  Yes      Age of surgery:

Has your child ever had ear tubes?  Yes      Age of surgery:

Please list any additional hospitalizations or surgeries:

**HEALTH HABITS**

Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea)  No       Yes      Amount per day:

**SCHOOL PERFORMANCE****CURRENT SCHOOL PERFORMANCE (if school-aged)**

Your child's grade:

Has your child ever repeated a grade?  No       Yes

Is your child enrolled in any special education class?  No       Yes

How many school days has your child missed so far this year?

How many school days did your child miss last year?

How many school days was your child late so far this year?

How many school days was your child late last year?

Child's grades this year:       Excellent       Good       Average       Poor       Failing

Child's grades last year:       Excellent       Good       Average       Poor       Failing

### FAMILY'S INFORMATION

MOTHER		FATHER
Age:		Age:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried
Education:		Education:
Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time		Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time
Occupation:		Occupation:

PERSONS LIVING IN HOME		
Name:	Relationship	Age

FAMILY SLEEP HISTORY	
Does anyone in the family have a sleep disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, mark the disorder(s):	
Insomnia	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Snoring	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Sleep apnea	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Restless legs syndrome	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Periodic limb movement disorder	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Sleepwalking/sleep terrors	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Sleep talking	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Narcolepsy	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent
Other:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/sister <input type="checkbox"/> Grandparent

REFERRAL	
Who asked that your child be seen by a sleep specialist?	
_____	Pediatrician/Family physician
_____	Child's parent or guardian
_____	Surgical specialist (e.g., ENT)
_____	Pediatric specialist (e.g., allergist, neurologist, pulmonologist)
_____	Mental health specialist (e.g. psychiatrist, psychologist, social worker)
_____	School teacher, nurse, counselor
_____	Child himself/herself
_____	Other:



# Northwest Houston Neurology, PA

455 School Street Suite 20

Tomball, TX 77375

Phone 281-357-5678 Fax 281-357-8765

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## Authorization to Release Protected Health Information

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security# \_\_\_\_\_ Date(s) of service. If all dates of service, write "all" \_\_\_\_\_

\_\_\_\_\_ I authorize the above named organization to **RELEASE my medical records to:**

\_\_\_\_\_ I authorize the above named organization to **RECEIVE records from:**

\_\_\_\_\_  
Person or Organization

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax (if applicable)

This information is being released for the following purposes:

( ) Continued Care ( ) Attorney / Litigation ( ) Insurance ( ) Disability ( ) Other \_\_\_\_\_

### INFORMATION TO BE RELEASED:

\_\_\_\_\_ Progress Note

\_\_\_\_\_ Diagnostics / Labs

\_\_\_\_\_ EMG Report

\_\_\_\_\_ Billing Records

\_\_\_\_\_ Sleep Study Reports

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Radiology Reports

\_\_\_\_\_ EEG or Video EEG

- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV; behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that I have a right to revoke this authorization at any time in writing and will present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. This authorization expires 180 days from the date of my signature unless specified in writing here: \_\_\_\_\_
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- **To the party receiving this information:** This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (If Legal Representative)

\_\_\_\_\_  
Patient or Legally Authorized Rep. Driver's License / ID#

\_\_\_\_\_  
Witness – Printed Name and Signature