Name: **ACCT#** **Noran Clinic Provider:**
DOB: **Age:** **Gender:**

What symptoms or neurologic condition are you being seen for today?
List:

Do you have any other new medical conditions? **Yes** **No** **Pregnant?** **Yes** **No**
List:

Have you been to the ER or hospitalized recently? **Yes** **No** **Recent Surgery? Yes** **No**
Details:

Have you had any recent changes in your job or family? **Yes** **No**
Details:

Are there any recent changes in your family's health? **Yes** **No**
Details:

Review of symptoms (mark below all that apply):

Head
__ headache
__ loss of vision
__ spinning dizziness
__ light headedness

Other Neurologic
__ difficulty concentrating
__ memory loss
__ trouble walking
__ falling
__ arm weakness
__ leg weakness
__ numbness / tingling
__ shaking / tremor

Other

Musculoskeletal
__ neck pain
__ mid back pain
__ low back pain
__ shoulder pain
__ knee pain
__ other joint pain

Psychiatric
__ depression
__ anxiety

Cardiovascular
__ palpitations
__ swelling of feet

Respiratory
__ shortness of breath

Gastrointestinal
__ vomiting
__ loss of bowel control

Genitourinary
__ frequent urination
__ loss of bladder control

Hematologic/Lymphatic
__ bleeding tendency
__ blood clots

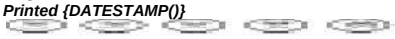
Skin
__ rash
__ hair loss

General
__ weight loss
__ weight gain

Sleep
__ snoring
__ choking/gasping in sleep
__ daytime sleepiness
__ morning headaches
__ waking feeling unrefreshed
__ difficulty falling asleep
__ aching/crawling sensation in legs
__ neck size 17 inches or larger

Circle the number that relates to your overall level of pain **today**:
(none) 1 2 3 4 5 6 7 8 9 10 (worst)

Signature: _____ **Date:**
Printed {DATESTAMP()}



Name: **NNC MD:** **ACCT#** **DOB:** **Age:**
Gender:

Past Medical History: mark below all that apply to you

__ Anemia
__ Angina
__ Anxiety Disorder
__ Arthritis
__ Arrhythmia
__ Asthma
Atrial fibrillation
Bipolar disorder
__ Cancer / Tumor
__ Chemical dependency
__ Deep vein thrombosis
__ Depression
__ Diabetes
__ Epilepsy/ seizures
__ Glaucoma
Heart attack
Heart failure
__ Hepatitis
__ High blood pressure
__ High Cholesterol
__ HIV / AIDS
__ Kidney problems
__ Multiple sclerosis
__ Neuropathy
Pacemaker
Parkinson's Disease
__ Rheumatoid arthritis
__ Sleep apnea
__ Stroke / TIA
__ Systemic lupus
__ Thyroid disease
__ Ulcers
_____
_____

Past Surgeries: write below your past surgeries and approximate year none

Past Injuries: write below your injuries and approximate date none

Medications: list drugs and dosing (if known) below

Allergies: list drugs and reaction below

Social History:

Education: How many years of school have you completed? _____ Are you in school now? yes no

Work Status: work FT work PT unemployed laid off temp. disabled perm. disabled retired

Are work hours restricted? yes no
Other restrictions? (List)

If not working: When did you last work? _____When might you return to work?_____

Occupation(s): Handedness: _____ right left
Military history? none current previous
Marital status: single partnered married separated divorced widowed

Number of children:_____

Tobacco use: Never Smoked Previous smoker, if quit, year quit? _____ Current Smoker, how much? _____ how often? _____
Unknown if ever smoked
Alcohol use: yes no Amount and frequency? _____ If quit, when? _____

Caffeine use: yes no Amount and frequency? _____ If quit, when? _____

Family History: mark below if a close relative (mother, father, sister, brother, child) has had any of the following problems:

Problem	Relative	Problem	Relative
Attention deficit disorder		Mental illness	
Alzheimer's disease/dementia		Multiple sclerosis	
Birth defect		Muscle disease	
Brain tumor		Neuropathy	
Brain aneurysm		Parkinson's disease	
Difficulty walking		Stroke	
Epilepsy/seizures		Tics/Tourette's	
Headaches/migraines		Tremor	
Huntington's chorea		Other neurologic	
Intellectual disability			

Mother: living deceased Father: living deceased

Patient Name: **Date of Birth:** **Account #:**

Sleep plays an important role in overall wellness, and sleep disturbance can significantly affect one's quality of health. There is growing evidence that sleep disorders can impact a number of neurological conditions, and neurological conditions can negatively affect sleep.

Please check below any statement that applies to you:

- I have been told I snore
- I have sudden shortness of breath/gasp for air in sleep
- I wake feeling unrefreshed in the morning
- I feel tired or fall asleep during the day even if I slept all night
- I wake frequently during the night and have racing thoughts
- I wake with morning headaches
- I have difficulty falling asleep
- I feel aching, crawling, cramping sensations in my legs
- I wake up with sore or stiff muscles
- My neck size is 17 inches or larger

<u>If you checked any of the boxes above, you may have a sleep problem that should be evaluated by a sleep specialist.</u>

"An estimated 70 million people in the United States suffer from sleep problems, and more than 50% of them have a chronic sleep disorder." -- National Institute of Neurological Disorders and Stroke

NAME: **ACCT#:** **DOB:** **SEX:**

NORAN NEUROLOGICAL CLINIC P.A. AND MINNESOTA DIAGNOSTIC CENTER RELEASE OF INFORMATION AND CONSENT FORM

Patient Information: By initialing, I acknowledge that I have received or reviewed the Notice of Privacy Practices of the Noran Neurological Clinic/Minnesota Diagnostic Center (NNC/MDC) and I acknowledge that the Notice is available to me upon request.
_____ **(Initials)**
Health Information Exchange and Health Record Locator Service: NNC/MDC may access patient information from a Health Information Exchange (HIE) or health record locator service to determine where a patient has received care and obtain information about a patient's health to help provide care for patients. By initialing, I acknowledge and agree that NNC/MDC may share my health record and information with an HIE or health record locator service.
_____ **(Initials)**
If I do not initial, I understand that NNC/MDC will exclude my information from the HIE or Health Record Locator Service.

Release of Information by Noran Neurological Clinic/Minnesota Diagnostic Center for Payment and Healthcare Operations: I authorize NNC/MDC, on behalf of myself and/or my dependents, to furnish medical records, including imaging and other information related to health care services provided by NNC/MDC, to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which NNC/MDC participate, and the contractors and third party administrators of any of these parties, as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations.

Release of Information by Others for Payment and Healthcare Operations: I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators, to share my health records and information obtained from NNC/MDC, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which NNC/MDC participates, and the contractors and third party administrators of these parties, as needed for payment and health care operations.

Release/Retrieval of Information to/from Health Care Facilities, Pharmacy Benefit Payers and Providers: I authorize the release or retrieval of my medical treatment information, including imaging, prescription medication history and other information related to such services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my medical treatment.

Voicemail, Text Messages and Email: I authorize NNC/MDC to use and disclose medical information to contact me in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to me. Noran Neurological Clinic may call me and, if necessary, leave a messages. Noran Neurological Clinic may send text message appointment reminders to my mobile device. Noran Neurological Clinic may email me regarding patient education.

I understand all of the above and have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent does not expire until I revoke it and I understand that any revocation must be done in writing. I understand that I have the right to revoke my consent at any time and that my revocation shall have no effect on any actions taken prior to my revocation.

Patient's Name (print)_____ Date_____

Signature of Patient (or Personal Representative)_____ Relationship to Patient if Patient Unable to Sign_____

AUTHORIZATION OF BENEFITS AND PAYMENT INFORMATION

Assignment of Benefits: I hereby assign all authorized medical and surgical benefits to which I am entitled, and I request payment of all such authorized benefits be made on my behalf, to Noran Neurological Clinic, for any services furnished by Noran Neurological Clinic or the Minnesota Diagnostic Center.
Payment Agreement: I understand that I am financially responsible and agree to pay for any charges for the care and treatment rendered to me not covered by my insurance plan or if I do not have active insurance coverage. I understand that if my primary insurance claim, no-fault motor vehicle insurance claim, workers compensation claim or personal injury insurance claim is denied that I am responsible for providing alternative insurance coverage or claim information. I understand that if I fail to provide alternative insurance or claim information within 30 days of a denial, the denied charges for services rendered to me will become my financial responsibility and due immediately.

Patient's Name (print)_____ Date_____

Signature of Patient (or Personal Representative)_____ Relationship to Patient if Patient Unable to Sign_____