TEXAS CHILD NEUROLOGY

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☐ Safiullah Shareef, MD
☐ Gerald So, MD, PA

PATIENT INFORMATION:

Last Name _____ First Name _____ MI_____
Preferred Name _____DOB _____ Social Security # ----------_____
Male ◯ Female ◯ Other ◯ Race: _____ Ethnicity: _____
Physical Address _____ Apt. # _____
City _____ State _____ ZIP Code _____

(If over 18) Patient phone #: _____Email: _____

Whom does the child live with? _____

Biological Parent's Marital Status: ○ Married ○ Divorced ○ Separated ○ Single

Is there a Court Order in place regarding child custody, visitation, or guardianship? ○ Yes ○ No

Primary Care Physician Name: _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____

MOTHER/LEGAL GUARDIAN INFORMATION:

Last Name:_____ First Name:_____Middle:_____
Social Security # ----------_____ Date of Birth: _____ Marital Status: _____
Home Number: (_____) _____ - _____ Work/Cell Number: (_____) _____ -_____
Parent/Guardian Email_____
Physical Address same as above ◯**YES** ◯**NO**
Address:_____ Apt# _____
City:_____ State:_____Zip: _____

FATHER/LEGAL GUARDIAN INFORMATION:

Last Name:_____ First Name:_____Middle:_____
Social Security # ----------_____ Date of Birth: _____ Marital Status _____
Home Number: (_____) _____ - _____ Work/Cell Number: (_____) _____ -_____
Parent/Guardian Email: _____
Physical Address same as above ◯**YES** ◯**NO**
Address_____ Apt#_____
City_____ State _____Zip_____

IN CASE OF AN EMERGENCY:

Emergency Contact: _____ Relationship: _____
Primary Number: (_____) _____ - _____ Secondary Number: (_____) _____ - _____

By typing your initials, name and date you are electronically attesting to the information you are providing to be true and accurate to the best of your knowledge. If you prefer to provide a handwritten signature, you may print the forms and sign them or request that we print them in the office for you to sign.

******INSURANCE INFORMATION (Please provide card(s) or proof of insurance must be presented at time of service) ******

◯ Blue Cross Blue Shield ◯ Aetna ◯ Cigna ◯ United Health Care ◯ Other

Primary Insurance (if other): _____

*Policy/Member/ID#: _____ *Group #: _____

*Claims Mailing Address: _____

*Policy Holder Name: _____

*Policy DOB: _____ *Policy Holder Social Security # ---------- _____

*Provider Service #: _____ *Place of Employment: _____

********WE ARE NOT ABLE TO FILE CLAIMS FOR ANY FORM OF MEDICAID********

*****Responsible Party:** Who should we issue a refund to if needed and/or statement: _____

If Responsible Party's information is not already listed on this form, please include on lines below:

Address_____ DOB: _____

Phone: _____ Relationship to Patient: _____

Consent to Email and Other Healthcare Communications

Patients in our practice may be contacted via email or text to remind them of an appointment, to obtain feedback on their experience with our healthcare team, and to provide general health reminders/information. If at any time, I provide an email address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

I authorize TCN and their agencies to contact me by the following method(s), please check all that apply:

☐ Home Number	☐ Mother Cell	☐ Father Cell
☐ Emergency Contact, when Necessary	☐ Mother Work	☐ Father Work
☐ Okay to email with detailed patient information	☐ Mother Email	☐ Father Email
◯ Leave Message with detailed patient information	◯ Leave Message with callback number only	

_____ _____

Signature of Parent/Guardian Date

PATIENTS WITH INSURANCE

Assignment and Authorization of Benefits

_____**Initial**, I hereby assign all medical benefits, to which I am entitled, private insurance, and other plans to Texas Child Neurology. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. ***We are not a network provider for any form of Medicaid, nor will Medicaid pay any claim out of network; therefore if you have Medicaid, we cannot file a claim on behalf of yourself or your child. You will be responsible for account balance***. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____ _____

Signature of Parent/Guardian Date

PRIVATE PAY OR PATIENTS WITHOUT INSURANCE

Financial acknowledgement

_____**Initial**, Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges occurring during the time of service.

_____ _____

Signature of Parent/Guardian Date

PRESCRIPTIONS

_____**Initial**, There is a $10.00 charge for all triplicate (controlled) prescriptions given outside of a regular office visit. We do not charge this fee if the script is given at the time of an office visit. A refill approval can be withheld if account is not in good standing. Our office requires 48-hour notice when requesting any medical refill. No refills are approved after hours. No refills will be given if your child has not been seen by the Physician in a year.

DISCLAIMER

_____**Initial**, You are informed by this Notice that Doctors Robert Chudnow, Mohsin Maqbool, and Gerald So hold a financial interest in Texas Health Center for Diagnostics and Surgery. You have the option, at your discretion, to use an alternate healthcare facility.

CANCELLATION/NO SHOWS/RESCHEDULES

_____**Initial**, There may be a $25.00 charge for patients who cancel, reschedule or NO SHOW an appointment without giving a 24-hour notice, as these appointment times could have been given to another patient.

Acknowledgement of Review of Notice of Privacy Practices

_____**Initial**-I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my child's healthcare information for treatment, payment, healthcare operations; and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice, if I have a question or complaint. To the extent permitted by law, I consent to the use, and disclosure of my child's information for the purposes described in the practice's Notice of Privacy Practices.

General Consent for Care and Treatment Consent

_____**Initial** This consent provides us with your permission to perform a reasonable and necessary medical examination, testing and treatment. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for your child. If you have any concerns regarding any test or treatment recommend by your child's health care provider, we encourage you to ask questions.

I voluntarily request Texas Child Neurology physicians, to perform a reasonable and necessary medical examination, testing, and treatment for the condition which has brought my child to seek care at Texas Child Neurology. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

_____ _____

Signature of Parent/Guardian Date

_____ _____

Printed Name of Parent/Guardian Description of Representative's Authority

PATIENT HIPAA FORM

Release of Information

_____**Initial** I hereby permit the practice, and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include, but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosure to Family and Loved Ones

You may authorize Texas Child Neurology to disclose information to family and/or friends. For example, you may prefer a family member or friend be present during your child's exam in your absence, or you may prefer someone to be allowed to discuss your child's health care such as a grandparent or step parent.

I AUTHORIZE TEXAS CHILD NEUROLOGY TO DISCLOSE INFORMATION TO FAMILY AND/OR FRIENDS OF MY CHOOSING.

- ☐ I agree with the above statement and authorize the individuals below.
- ☐ I DO NOT agree or authorize the disclosure of my child's information to anyone other than the Biological Parents or Legal Guardians.

I authorize the individuals listed below access to my child's personal health information:

Please list individual, relationship to patient, and phone number they can be reached.

Family/Friend _____

Family/Friend _____

Family/Friend _____

This disclosure will remain valid until a new written authorization is completed.

Patient's Name _____ Date of Birth _____

Parent or Guardian Signature _____ Date _____

Texas Child Neurology, PLLC

4032 McDermott Rd, Suite 100 Plano, TX 75024

TEXAS CHILD NEUROLOGY, PLLC
4032 McDermott, Suite 100
PLANO, TEXAS 75024
Ofc. # 972-769-9000 Fax # 972-769-0035

Date: _____

Patient's Name_____

Date of Birth _____Age _____School grade _____

Pediatrician or Family doctor _____Office phone _ - -_____

Home Address_____Fax_____

Referring physician _____

Pharmacy Name: _____Phone Number: _____

Address:_____

Other Neurologists that you have seen: _____

CHIEF PROBLEM: Please write a brief statement describing your child's neurological condition

_____

_____

_____

LIST ALL CURRENT MEDICATIONS AND DOSAGES

_____ _____ _____ _____ _____ _____

LIST ALL ALLERGIES TO MEDICATIONS

PATIENT HISTORY - GENERAL MEDICAL

Has your child had all the immunizations recommended for his or her age? ☐ YES ☐ NO

Has your child ever been hospitalized for a medical (nonsurgical) problem? List hospital and child's age.

_____

Any operations? (Give hospital and child's age and reason for surgery)

_____

Has your child ever complained of or been seen by a physician for:

☐ Dizziness	☐ Frequent Vomiting	☐ Skin Problems
☐ Headaches	☐ Feeding Problems	☐ Abnormal weight loss/gain
☐ Blurred or abnormal vision	☐ Slow Development	☐ Difficulty tolerating heat or cold
☐ Hearing Problems	☐ Learning Difficulties	☐ Fainting spells
☐ Seizures without fever	☐ Growth Failure	☐ Chronic fatigue
☐ Seizures with fever	☐ Hyperactivity	☐ Genetic Diseases
☐ Migraine Headaches	☐ Intellectual Disability	☐ Cerebral palsy
☐ Birth defect	☐ Weakness of muscles	☐ Tingling or numbness in feet or hands

DEVELOPMENTAL HISTORY

Pregnancy and newborn history:

Did you carry your child for the full 9 months? ☐ YES ☐ NO If no how long? _____

Child's birth weight _____ Birth length _____ Inches _____

Medications during pregnancy _____

Problems during pregnancy: _____

Illnesses _____ Infections _____ Other _____

Labor: Length of labor _____ hours. Any difficulties? _____

Delivery: ☐ Vaginal ☐ C-section If C-section, why? _____

Any difficulties? _____

Did your child come home from the hospital with you? ☐ YES ☐ NO

Any special care needs in infancy? ☐ YES ☐ NO

Growth and developmental milestones:

At what age did your child?

Sit _____ Say first words _____ Stand _____

Walk _____ Speak in sentences _____ Toilet train _____

Family History

Please check if the family members below have any of the following medical problems.

Condition	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Siblings
Healthy	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Kidney Disorder	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Other							

Neurological Disorders

Condition	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Siblings
Anxiety	☐	☐	☐	☐	☐	☐	☐
Brain Tumor	☐	☐	☐	☐	☐	☐	☐
Cerebral Palsy	☐	☐	☐	☐	☐	☐	☐
Dementia / Alzheimer's	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐
Learning Disability (Dyslexia, ADHD, other)	☐	☐	☐	☐	☐	☐	☐
Manic-depression	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Migraine Headache	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐
Muscle Disease	☐	☐	☐	☐	☐	☐	☐
Nervous Breakdown	☐	☐	☐	☐	☐	☐	☐
Neurofibramatosis	☐	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐	☐
Peripheral Neuropathy	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Tuberous Sclerosis	☐	☐	☐	☐	☐	☐	☐

Any other medical conditions that run in the family, not mentioned above?

_____

_____

Have family members had substance abuse (alcoholism or drug abuse)? _____

Are any family members in prison? _____

Have there been any suicide attempts with any family members? _____

School Information:

Did you have special concerns about development or behavior when he/she was a toddler or pre-school age?

_____

_____

How has your child performed in school? _____

Has the school system provided any special accommodations for your child? _____

What are your child's interests or hobbies? _____

Has your child had any of these tests?

TEST	DATE	WHERE DONE	RESULTS
MRI	_____	_____	☐ **normal** ☐ **abnormal**
CT	_____	_____	☐ **normal** ☐ **abnormal**
EEG	_____	_____	☐ **normal** ☐ **abnormal**
EMG	_____	_____	☐ **normal** ☐ **abnormal**

_____ _____

Parent/ Guardian **Date**