Advanced Neurodiagnostic Center

New Patient Information

Date: _____

Name: _____ Date of Birth: _____
Last First Middle

Address: _____
Street City State Zip Code

Work Phone: _____ Home Phone: _____ Cell Phone: _____

SSN: _____ Drivers License #: _____ Email: _____

☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

---

Employer: _____ Occupation: _____

Address: _____
Street City State Zip Code

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Address: _____
Street City State Zip Code

Medical Insurance Provider: _____

Group / Policy #: _____ Provider Phone #: _____

Address: _____
Street City State Zip Code

Make checks for medical and/or surgical expenses due to me under this policy payable to *Advanced Neurodiagnostic Center*. I realize this may not represent the full payment and I will be responsible for the balance due. A photo static copy of this authorization will be used as the original.

Signature: _____

2905 Kingman Street, Metairie, LA 70006 504-885-3737 fax: 504-885-5507
2220 Worley Drive, Alexandria, LA 71301 318-442-8900 fax: 318-442-8920
www.adneuro.com

Initials: _____

1. **Is this medical visit due to a motor vehicle accident or fall with a possible or pending personal injury case that involves an attorney?** ☐ **Yes** ☐ **No**

   Attorney: _____ Phone #: _____

2. **Is this medical visit due to an injury that occurred while on the job with a possible or pending workmen's compensation case?** ☐ **Yes** ☐ **No**

   Industrial Carrier: _____ Phone #: _____

   Address: _____
   Street City State Zip Code

   Work. Comp. Attorney: _____ Phone #: _____

If you answered YES to either question 1 or 2, please complete the remainder of this page.

If you answered NO to both questions 1 and 2, please mark an N/A on the page and proceed to page 3.

Please provide us with the details of your accident / injury:

Date of accident / injury: _____

What kind of accident was it (car, truck, work related etc.): _____

_____

How did the accident / injury occur? _____

_____

Did you go to the emergency room? ☐ Yes ☐ No

If yes, which hospital? _____

What tests have you had? (MRI, CT scan, X-ray, Blood tests) _____

_____

Have you seen any other doctor or therapists; if so please list their names: _____

_____

Patient Health Information

1. Please list any other family member or friends, if any, other than the emergency contact person, who we may inform about your medical condition and diagnosis if needed. This includes treatment, payment and/or other pertainent healthcare information:

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

2. Please print the address of where you would like your billing statements and correspondence from our office to be sent, if other than your home address:

   Address: _____
   Street City State Zip Code

3. Please print the telephone number where you want to receive calls about your appointment, if other than your home phone number. Please be aware that a cell phone is not a secure line or a private one.

   Phone #: _____

4. Can a confidential message (ie appointment reminders) be left on your voicemail: ☐ Yes ☐ No

Please notify the clinic of any changes in information (ie address / phone) as soon as possible

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

I acknowledge that I have been provided a copy of this notice.

Patient Name (print): _____

Patient Name (signature): _____

Date: _____

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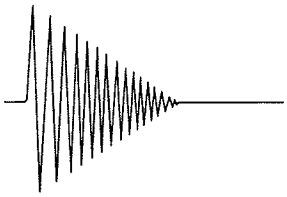


Advanced Neurodiagnostic Center

Release of Benefits

I hereby instruct (insurance carrier): _____

To Pay: Advanced Neurodiagnostic Center
2905 Kingman Street
Metairie, Louisiana 70006

1. I instruct the expense benefits allowable and payable to me under my current insurance policy as payment to the total charges for professional services paid directly to Advanced Neurodiagnostic Center. The payment will not exceed my indebtedness to the above mentioned assignee.

2. I have agreed to pay, in the current manner, any balance of said professional service charges over and above the insurance payment.

3. I understand that if insurance benefits are denied for any reason, I am responsible in full for the charges incurred at this facility.

I authorize Advanced Neurodiagnostic Center to release any information pertinent to my file to any insurance company, adjustor, attorney involved in this case, and hereby release Advanced Neurodiagnostic Center of any consequence thereof.

Patient Signature: _____

Date: _____

Release of Medical Records to Advanced Neurodiagnostic Center

I, _____ hereby authorize to release all of my medical records, including history and physicals, discharge summaries, consultation reports, progress notes, laboratory and diagnostic imaging films and reports to:

Advanced Neurodiagnostic Center
2905 Kingman Street
Metairie, Louisiana 70006
(504) 885-3737 (504) 885-5507 Fax

Patient Signature: _____ Date: _____

Date: _____

Release of Medical Records from Advanced Neurodiagnostic Center

I, _____ hereby authorize,

Advanced Neurodiagnostic Center
2905 Kingman Street
Metairie, Louisiana 70006
(504) 885-3737 (504) 885-5507 Fax

to release all of my medical records, including history and physicals, discharge summaries, consultation reports, progress notes, laboratory and diagnostic imaging films and reports to the following:

_____

_____

Patient Signature: _____ Date of Birth: _____

Date: _____

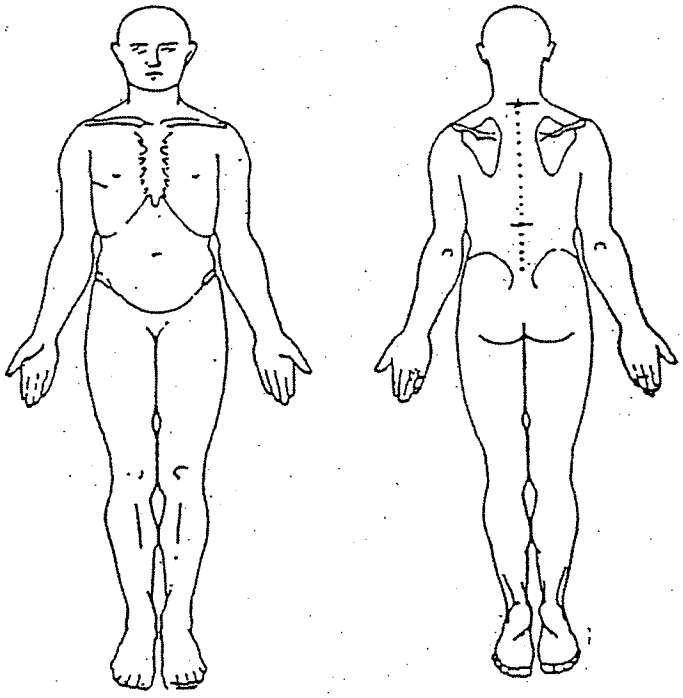
Advanced Neurodiagnostic Center

Patient Medical Information

Name (Print): _____ Date: _____

Chief Complaint: _____ Referring Physician: _____

Pain Diagram: (Shade specific areas of pain, numbness, tingling, if applicable)



Pain Score: (Circle Number)

No Pain — Severe Pain

0 1 2 3 4 5 6 7 8 9 10

Past Medical History: (List any condition which you are taking medications for now or have had in the past)

_____ _____

_____ _____

Past Surgical History:

_____ _____

_____ _____

Allergies: _____

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Medications:

_____ _____

_____ _____

Family History: (cancer, Diabetes, heart disease, etc)

_____ _____

Past History of MVA or work related injuries: ☐ Yes ☐ No; if yes, please explain and list dates:

_____

Social History: ☐ ☐

Tobacco Use: Yes No; if yes, packs per day _____ and years of use _____

Alcohol Use: ☐ Yes ☐ No; if yes, amount per week _____

Illicit Substance used in the past: ☐ Yes ☐ No; if yes, type and amount _____

Work Status: Are you employed ☐ unemployed ☐ disabled ☐ retired ☐ Student ☐

Review of Symptoms: (Please check all that apply)

Neurological / Psychiatric
- ☐ Headaches
- ☐ Fainting
- ☐ Convulsions
- ☐ Paralysis
- ☐ Speech Problems
- ☐ Memory Problems
- ☐ Hallucinations
- ☐ Tremors
- ☐ Sleep Disturbances
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Sleep
- ☐ Psychiatric treatments

Musculo-Skeletal
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Cramps
- ☐ Muscle Weakness

Skin
- ☐ Rashes
- ☐ Bruising

Constitutional
- ☐ Weight gain / Loss
- ☐ Fever
- ☐ Chills
- ☐ Tiredness / fatigue
- ☐ Weakness

Cardiovascular
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Poor Circulation
- ☐ Irregular Heart beat
- ☐ Swelling of ankles / legs
- ☐ Low blood pressure

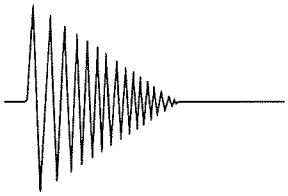
Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough
- ☐ Wheezing
- ☐ Cough of blood

Genito-Urinary
- ☐ Blood in urine
- ☐ Difficulty in urinating

Endocrine
- ☐ Diabetes
- ☐ Low Sugar
- ☐ Hypo / Hyper Thyroid

Gastro-Intestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Bloating

Eyes / Ears / Nose / Throat
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye pain
- ☐ Loss of vision
- ☐ Earache
- ☐ Nosebleed
- ☐ Ringing in Ears / Tinnitus
- ☐ Hoarseness



Advanced Neurodiagnostic Center

Head Trauma Questionnaire

Patient Name: (Print) _____ Date: _____

1. Have you had any form of head trauma during an accident or injury? ☐ Yes ☐ No

   If Yes, please complete the following questions. If No, please proceed to the next page.

2. Did you recover completely from this trauma? ☐ Yes ☐ No; if no, what residual symptoms do you have: _____

3. Did you have any head trauma associated with your current accident or injury? ☐ Yes ☐ No; if yes, please check the symptoms which apply to you below.

4. Did you lose consciousness (get knocked out) for any period of time? ☐ Yes ☐ No

5. Were you dazed or confused after the head trauma? ☐ Yes ☐ No

Symptoms of Concussion

Please check all that apply to the way you felt or continue to feel after your head trauma.

☐ Blurred Vision	☐ Nausea
☐ Dizziness	☐ Nervousness
☐ Drowsiness	☐ Personality change
☐ Excessive Sleep	☐ Poor balance or coordination
☐ Easily distracted	☐ Poor concentration
☐ Fatigue	☐ Ringing in ears
☐ Feel "in a fog"	☐ Sadness
☐ Headache	☐ Seeing Stars
☐ Inappropriate emotion	☐ Sensitivity to light or noise
☐ Irritability	☐ Sleep disturbance
☐ Memory Problems	☐ Vacant stare or glassy eyed
☐ Confusion	☐ Vomiting

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Sleep Disorder Questionnaire

Please check all of the following that applies to you:

- ☐ I have been told that I snore.
- ☐ I have been told that I stop breathing while I sleep.
- ☐ I feel sleepy during the day, even after a good night's sleep.
- ☐ I have been forgetful.
- ☐ I regularly experience muscle tension in my legs.
- ☐ High blood pressure
- ☐ I have difficulty falling asleep.
- ☐ I have difficulty staying asleep.
- ☐ I have headaches in the morning.
- ☐ I am overweight.
- ☐ I have difficulty concentrating at work.
- ☐ I am a restless sleeper.
- ☐ I wake up tired.
- ☐ I find myself getting short tempered.

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = would never fall asleep
1 = slight chance of falling asleep
2 = moderate chance of falling asleep
3 = High chance of falling asleep

Situation	Chance of dozing
Sitting and reading:	_____
Watching television	_____
Sitting inactive in a public place (ie theater or meeting)	_____
As a passenger in a car for an hour without a break:	_____
Lying down to rest in the afternoon:	_____
Sitting and talking quietly to someone:	_____
Sitting quietly after lunch without alcohol:	_____
In a car while stopped for a few minutes in traffic:	_____
Total:	_____

If you have checked off two or more of the above symptoms or have a total Epworth score of 10 or higher, you may have a sleep disorder. Some sleep disorders can have a serious effect on your health. Advanced Sleep Center is accredited by the American Academy of Sleep Medicine and we have specialist to evaluate, diagnosis and treat your sleep disturbance.

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CHRONIC PAIN AGREEMENT / CONSENT FORM

Due to an underlying medical condition your quality of life may be limited by chronic pain. The goal of Advanced Neurodiagnostic Center (ANC) is to allow you to regain control of your life. Although the condition that is responsible for your pain may not be curable, all attempts will be made to treat and improve that underlying condition. As part of your treatment plan, opiate (pain) medications as well as other federally controlled medications may be required to treat your chronic pain. You, the patient, will actively take part in your treatment plan. As a patient, you must agree to the following in order for the physicians at ANC and/or affiliated facilities to effectively treat your pain.

I Understand:

- The purpose of this agreement is to protect my access to controlled medications and to protect the ability of the physicians at ANC to prescribe them to me.
- The long-term use of such medications as opioids (pain medications), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit.
- These medications may cause sleepiness, dizziness and occasional euphoria (overly happy feeling). I have been advised that I should not drive a car or any other vehicle, operate machinery or unnecessarily expose myself to hazards while on these medications. If I choose to drive, I am responsible for my own safety and the safety of others.
- The adverse effects often experienced while taking pain medications include chemical dependence (addiction), constipation, difficulty with urination, drowsiness, nausea, itching, depressed respirations and reduced sexual function.
- Because these medications have potential for abuse or diversion, strict accountability is necessary. This is especially true when its use or anticipated use is prolonged.
- If I develop signs of addiction (manipulative drug craving behavior to obtain mental numbness or euphoria) I will notify the physicians at ANC in order for my medicines to be slowly decreased and then stopped.
- Withdrawal symptoms may occur if pain medications are stopped abruptly. They include yawning, sweating, runny nose, anxiety, tremors, hot and cold flashes, abdominal cramps and diarrhea.
- I have been advised that these medications may be harmful to an unborn child. If I become pregnant I will notify my treating physician at ANC immediately.
- Since these medications may be hazardous or lethal to person who is not tolerant to their effects, especially a child, I will keep them out of the reach of such people.

Initials: _____

Advanced Neurodiagnostic Center

I promise:

- While being treated by my physician for pain management, I **will not** obtain controlled medications (For example, Xanax, Vicodin, Percocet, Tylenol #3, etc.) from any other physician without first telling my physician at ANC.
- Only the physicians at ANC will prescribe these controlled medications for me. Receiving multiple prescriptions of the same or similar controlled medications, whether intentional or not, can lead to significant drug interactions and poor coordination of treatment.
- I will inform ANC of any new medications or medical conditions, and any adverse effects that I may experience from any of the medications that I take.
- I will come to my regularly scheduled appointments and understand that refills will not be given unless I am seen on a regular basis, usually no more than every 3 months.
- If my physician requests me to submit to random drug testing (urine or serum) to monitor for drug use that my doctor has not prescribed, I agree that I will do this drug testing. If I test positive for drugs that my doctor has not prescribed and/or if I refuse a random drug screen, my physician may choose to end his/her doctor – patient relationship with me and refer me to a drug dependency treatment program.
- I **will not** use illegal drugs (marijuana, cocaine, heroin, etc.) Presence of any illegal substance on a drug test will be cause to decrease and stop my controlled substances and/or dismissal from the clinic.
- I will have my pain medications filled at only one pharmacy, which is:

  _____ Phone# _____ Fax# _____
- I hereby authorize ANC to fax or send any information related to my use of controlled substances to this pharmacy. If for some reason I am unable to obtain the controlled substances at this pharmacy and I am forced to go to another pharmacy, I will notify my pain management doctor of this situation and provide the name and telephone number of the pharmacy I was required to use.
- I will take my medications as directed. **If I use up my medications sooner than prescribed for whatever reason, I understand that the physician will not replace them**. Each prescription is expected to last one month.
- I will call the office at least 5-6 business days in advance to request a refill prescription. Calls should be made to the office during regular business hours and prescriptions shall be picked up in person if necessary. Refill prescriptions will not be written at night, holidays or on weekends. I will make no attempts to obtain pain medications during this time. **If at any time my pain gets a lot worse, I will go to the emergency room.**
- I **will not** request an early refill if I "run out early", "lose a prescription", "spill", or "misplace" my medications. If my medication is stolen I will report this to my local police department and obtain a stolen items report. The doctor will decide if my prescriptions are to be replaced.
- I **will not** share, sell, or otherwise permit others to have access to any of my prescription medication.
- I will bring all of my controlled (pain) medications in their bottle to each office visit for monitoring.

Initials: _____

Advanced Neurodiagnostic Center

Waiver of Confidentiality:

- I give the physicians at ANC and/or any treating physician within an affiliated facility permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my healthcare for purposes of maintaining accountability.
- If responsible legal authorities have questions concerning my treatment (For example obtaining medications at several pharmacies) I understand all confidentiality is waived and these authorities may be given full access to my records of controlled substances administration.

It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit to you, as determined by your treating physician at ANC or its affiliated facilities.

Failure to adhere to these policies may result in cessation of therapy with controlled substances which are prescribed by your treating physician or referral for further specialty assessment.

You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand and accept all of its terms.

Patient Signature	Date	Patient Name (Printed)

Physician Signature	Date

Witness	Date

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