Patient Demographics (page 1 of 2)

_____ **Male / Female** _____

Patient's Legal Name **Nickname**

_____ _____ _____ - _____ - _____

Date of Birth **Age (weeks, months or years)** **Patient's Social Security No.**

_____

Patient's Address

_____

Reason for Referral

_____ _____

Primary Care Physician (PCP) **Tel #** **Referring Physician (if different from PCP)** **Tel #**

What insurance covers the patient? _____ What is your copay? _____

Who carries the insurance (guarantor)? _____ What is your co-insurance?_____

_____ _____ - _____ - _____ _____

Guarantor's Date of Birth **Guarantor's SSN** **Guarantor's Contact Numbers**

Patient is your: ☐ Natural Child ☐ Adopted Child ☐ Foster Child ☐ Other: _____
Are patient's parents divorced? ☐ No ☐ Yes: ☐ Is in DHS custody
If yes, please explain custody: Mom has _____ % Dad has _____ % Documentation given? ☐ yes ☐ no

For patient's parents / legal guardians:

Here today? ☐ yes ☐ no

_____

Name **Relation to patient**

_____

Date of Birth **Social Security Number**

_____

Address if different from patient's

_____

Address

_____

Home Tel # **Mobile Tel #**

_____

Employer **Work Tel #**

_____

Emergency Contact #1 other than parents/guardians Tel #

Here today? ☐ yes ☐ no

_____

Name **Relation to patient**

_____

Date of Birth **Social Security Number**

_____

Address if different from patient's

_____

Address

_____

Home Tel # **Mobile Tel #**

_____

Employer **Work Tel #**

_____

Emergency Contact #2 other than parents/guardians Tel #

Patient Demographics (page 2 of 2)

Has patient seen anyone for this problem in past? ☐ No ☐ Yes: Who? _____When? _____
Has patient been in the hospital for problem? ☐ No ☐ Yes: (continue below)
Where? St Francis? ☐ No ☐ Yes: When? _____
St John? ☐ No ☐ Yes: When? _____
Hillcrest? ☐ No ☐ Yes: When? _____
TRMC? ☐ No ☐ Yes: When? _____
Has patient had any tests for this problem? EEG ☐ No ☐ Yes: When? _____Where?_____
MRI ☐ No ☐ Yes: When? _____Where?_____
CT ☐ No ☐ Yes: When? _____Where?_____
Lab work ☐ No ☐ Yes: When? _____When? _____
Is patient's problem related to an injury or accident? ☐ No ☐ Yes:
If yes, do you plan a lawsuit or is a lawyer involved? ☐ No ☐ Yes:

☒ I've received the Notice of Privacy Practices
☒ I understand how medical information about me/my child may be used and disclosed and how I can get access to the information.
☒ I agree to allow CNOT to use email, facsimile and telephone as a means to provide care
☒ I agree to assign insurance payments for provided services directly to Child Neurology of Tulsa, P.C.
☒ I accept the financial responsibility for services provided by Child Neurology of Tulsa, P.C. in the case that my insurance denies payments of services or was not authorized. If I have no insurance or Dr. Siegler is "out-of-network" for my insurance I understand that I will be responsible for the entire charge which is due at the time of service.
☒ I am aware of the cancellation policy and of services typically not covered by third party payors (insurance) and that I will be responsible for such charges:

- Minimum $25 charge for after hour services, forms, letters, bounced checks, billed copays, etc.
- $100 for failure to show or cancel new/comprehensive visit within 2 working days
- Full cost $395 for failure to show or cancel 2nd new/comprehensive visit within 2 working days
- $25 for failure to show or cancel return visits within 2 working days
- Repeated failure to show or cancel appointments may result in firing from the practice

☒ I agree that in any ongoing or future legal matters that Dr. Siegler/Erin Sparks, ARNP will be paid for their time in any related role at their usual and customary fees.
☒ I understand that only legal guardians will be included in the patient's care and any additional people I wish to be involved requires written legal notification
☒ I, hereby, give CNOT consent to ongoing evaluation, treatment and prescribing of said patient. Any change to this consent requires notarized written notification.
☒ I have read the above and understand and agree to all the statements as evidenced by my signature:

_____
Signature Relationship to Patient Date

_____
Signature Relationship to Patient Date

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