Arthur Nwaubani, M.D.

Board Certified pediatric Neurologist/Epileptologist and Clinical Neurophysiologist

anwaubani@cnaec.us

312 S. Lake Street
Leesburg, Florida 34748
Phone: 352-431-3600
Fax: 352-460-0853

www.childneurologyandepilepsycenter.com
www.cnaec.us

Thank you for selecting Child Neurology And Epilepsy Center for your healthcare needs and concerns. We look forward to you joining our family.

Please help us provide you with the best of care by taking time to review and complete the enclosed new patient forms. Return these forms to our office prior to your appointment with Dr. Nwaubani. This will provide us with the necessary information we need to have our first new patient appointment together as thorough as possible. It is very important that the paperwork is completed entirely.

Be sure to fill out the "authorization for Release of Medical Information." This will enable our office to obtain medical records and/or test results for Dr. Nwaubani.

Should you have any questions regarding the enclosed forms, please do not hesitate to contact the office.

Your Appointment Date and Time: _____

Sincerely,

Dr. Nwaubani and Staff

CHILDNEUROLOGYANDEPILEPSYCENTER

PATIENTREGISTRATION

PATIENT INFORMATION:			
Patient Name:		Social Security #	
Address:	City:	State:	Zip:
Date of Birth:	Sex: M F	Home#:	

PEDIATRICIAN/PRIMARY CARE			REFERRING PHYSICIAN:		
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City	State:	Zip:
Tel#			Tel#:		

RESPONSIBILITY PARTY INFORMATION

Mother's Name:			Father's Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Social Security:			Social Security:		
Date of Birth:			Date of Birth:		
Home #:			Home#:		
Cell#:	Work#:		Cell#:	Work#:	
Employer/Occupation:			Employer/Occupation:		
E-mail Address:			E-mail Address:		

INSURANCE INFORMATION			OTHER INFORMATION
Primary Insurance:			Pharmacy Name:
Policy Holder Name:			Phone:
Social Security:	DOB:		Any known allergies:
Insurance Address:			
City:	State:	Zip:	
Phone: Effective Date:			ID#: Group:

EMERGENCY CONTACT INFORMATION

Relationship to patient:	Name:	
Telephone #:	Cell #:	Work#

PEDIATRIC HEALTH QUESTIONNAIRE

Mother's Name:_____ Father's Name: _____

Primary Care Physician:_____ Name of School: _____

Drug Allergies/ Reactions: Current Medications:

_____ _____

_____ _____

_____ _____

Birth History:

Birth Weight: _____ Full-Term: Yes _____ No_____ Pre-Term:_____ Late:_____

Problems During Pregnancy:_____ During Delivery:_____

Delivery: Vaginal _____ C-Section _____ Vaccinations Up To Date: Yes:_____ No:_____

Past Medical History: Please Mark with a *check mark* for YES

☐	Asthma	☐	Measles	☐	Developmental Delay
☐	Ear Infections	☐	Sinus Problems	☐	Speech Problems
☐	Pneumonia	☐	Breath Difficulties	☐	Seizure Disorder
☐	Kidney Disease	☐	Heart Problem/Murmur	☐	Liver Disease
☐	Thyroid	☐	Urinary Infections	☐	Vision Problems
☐	Bleeding Disorder	☐	Diabetes	☐	Snoring
☐	Constipation	☐	Diarrhea	☐	Headache
☐	Allergies	☐	Skin Problems/Rashes	☐	Throat Infections
☐	Bronchitis	☐	Syncope	☐	Anemia
☐	Chicken Pox	☐	Loss of Consciousness	☐	Other
☐	Other	☐	Other	☐	Other

Hospitalizations: Surgeries:

_____ _____

_____ _____

Family History: Please Mark with a *check mark* for YES

☐	High Blood Pressure	☐	Cancer	☐	Lung Disease
☐	Diabetes	☐	Birth Defects	☐	Developmental Delay
☐	Thryroid	☐	Sickle Cell Disease	☐	Headaches
☐	Heart Attacks	☐	Asthma	☐	Alternation in Awareness
☐	Strokes	☐	Alcohol Abuse	☐	Syncope
☐	Heart Disease	☐	Drug Abuse	☐	Other
☐	Cholesterol	☐	Bleeding Disorders	☐	Other
☐	Deafness	☐	Muscular Disorders	☐	Other

CHILD NEUROLOGY AND EPILEPSY CENTER

312 S. Lake Street
Leesburg, Florida 34748
Phone: 352-431-3600 Fax: 352-460-0853

PEDIATRIC SOCIAL HISTORY

DIET
Regular
Vegetarian
Vegan
Gluten Free
Specific Carbohydrate
Cardiac
Diabetic

CAFFEINE INTAKE
None
Occasional
Moderate
Heavy

EXERCISE LEVEL
None
Occasional
Moderate
Heavy

SPORTING ACTIVITIES _____

PARENTS MARITAL STATUS
Married
Unmarried
Separated
Divorced
Widowed

HOME SITUATION
Both Parents
Mother
Father
Relatives
Adoptive Parents
Foster Parents
Other

SIBLINGS _____

CHILDCARE
None
Relative
Private Sitter
Daycare/Preschool

ANIMAL EXPOSURE
Yes _____
No _____

PASSIVE SMOKE EXPOSURE
Yes _____
No _____

SMOKE/CO DETECTORS IN THE HOME
Yes _____
No _____

SEAT BELT/CAR USED ROUTINELY
Yes _____
No _____

SUNSCREEN USED ROUTINELY
Yes _____
No _____

INSECT REPELLENT USED ROUTINELY
Yes _____
No _____

GUNS PRESENT IN THE HOME
Yes _____
No _____

YEARS IN SCHOOL
Pre-K
Kindergarten
Grade_____
HS Graduate
College_____

SCHOOL NAME _____

SMOKING STATUS
Never Smoke
Smoke
Unknown

WATER
Fluoridated
Non-Fluoridated
Unknown

NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

CHILD NEUROLOGY AND EPILEPSY CENTER

312 S. Lake Street
Leesburg, Florida 34748
Phone: 352-431-3600 Fax: 352-460-0853

Authorization to Release Medical Records and Insurance Assignment

Patient Name: _____

Date of Request: _____ **Date of Birth:** _____

_____**(Initial)** I authorize Dr. Arthur Nwaubani to obtain personal health information which includes but not limited to: admission dictation, discharge summeries, operative notes, immunizations, laboratory reports, radiology, MRI, CT, EEG, EKG and any other condition, treatment and evaluation of care.

_____**(Initial)** I authorize Child Neurology and Epilepsy Center (CNAEC), to release my medical records and personal information to healthcare providers involved in my child's continuing care and treatment.

_____**(Initial)** I authorize the release of my child's medical records to Child Neurology and Epilepsy Center (CNAEC), to release them from all responsibility and/or liability that may arise from this authorization.

_____**(Initial)** I authorize Child Neurology and Epilepsy Center (CNAEC), to release to any third party (such as an insurance company or government agency) any medical information and records concerning diagnosis and treatment when requested for use in determining claim for payment

_____**(Initial)** I permit a copy of authorizations and assignments to be used in place for this original that is on file at Child Neurology and Epilepsy Center (CNAEC).

Child Neurology and Epilepsy Center (CNAEC), can disclose detailed medical information such as, but not limited to results, diagnosis and findings at the numbers initialed and listed below:

_____**(Initial) HOME #:** _____ _____**(Initial) HOME VOICEMAIL #**

_____**(Initial) CELL#:** _____ _____**(Initial) CELL VOICEMAIL #**

_____**(Initial) WORK#:** _____ _____**(Initial) WORK VOICEMAIL#**

_____**(Initial) FAX# :** _____

Responsible Party's Signature: _____ **Date:**_____

Emergency Contact:_____ **Relation:**_____

Home #: _____ **Cell#:**_____

Child Neurology And Epilepsy Center

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

PATIENT ACKNOWLEDGEMENT FORM

Patient Name: _____ **Date of Birth:**_____

Responsible Party: _____ **Relationship:**_____

Our Notice of Privacy Practices provides information about how Child Neurology and Epilepsy Center (CNAEC) may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. Please review our Notice thoroughly before signing this Acknowledgement Form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and healthcare operations. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations.

This notice describes how medical information about you may be disclosed. Please review it carefully. CNAEC will use your medical information for the following:

- **TREATMENT:** Including providing your medical records to consulting clinicians and insurance companies.
- **PAYMENT:** We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.
- **HEALTHCARE OPERATIONS:** Any others involved in your healthcare.

The entire **PRIVACY POLICY NOTICE of CNAEC** is posted in waiting room for perusal.

In conjunction with these privacy practices you will need to provide us with the following information:

I give permission for Child Neurology and Epilepsy Center (CNAEC) to:

_____**(Initial)** May communicate with you my mail or leave a message on your designated phone number/answering machine in regards to your healthcare or an upcoming appointment.

_____**(Initial)** May share medical information with:

Name: _____ **Relationship:**_____

Name: _____ **Relationship:**_____

I have been informed and understand both the patient notice of privacy practices and informed consent listed about by Child Neurology and Epilepsy Center (CNAEC).

_____ _____

Signature of the patient **OR** legal representative and relationship to the patient Date

Witness Initials: _____ Date:_____

CHILD NEUROLOGY AND EPILEPSY CENTER
FINANCIAL POLICY
MUST BE SIGNED BY THE RESPONSIBLE PARTY

Patient's Name: _____

Patient's Date of Birth: _____

I understand that if my insurance policy requires pre-authorization by the referring agency, it is my responsibility to obtain and provide it to Child Neurology and Epilepsy Center.

I understand that it is my responsibility to supply the most current primary insurance coverage or any changes in insurance coverage and provide it to Child Neurology and Epilepsy Center prior to services rendered. I understand that I am required to pay any copay coinsurance, and/or deductible in full prior to service rendered. I understand that I am responsible for the entire amount due for professional services if my child is registered as **Self Pay** or I have failed to provide correct and current coverage or regardless of insurance coverage that retroactive back to the date of services were rendered.

Child Neurology and Epilepsy Center **DOES NOT** file secondary insurance claims.

In the event Child Neurology and Epilepsy Center is not contracted with my insurance company or my insurance denies payment for any reason, I am responsible for the entire amount due for the professional services rendered.

I understand payment is due in full prior to services rendered and that I will be provided a receipt so that I may file with my insurance company, if I choose to do so.

Responsible Party's
Signature:_____Date:_____

NOTE: If insurance is terminated after the date of service or incorrect primary insurance is given at time of service and insurance denies payment or requests reimbursement of payment, patient will be responsible for the full amount (entire balance) within 30 days or be sent to collections.