Little Buddies Child Neurology PLLC
Yuliya Snyder, M.D., M.S.
Diplomate of the American Board of Psychiatry and Neurology
1655 Elmwood Ave, Suite 222
Rochester, NY 14620
(585) 542-9272 (phone)
(585) 360-2026 (fax)
www.littlebuddieschildneurology.com

Dear Patient,

Welcome to Little Buddies Child Neurology. We are excited to have you as a new patient.
Your appointment with Dr. Snyder is scheduled for _____ at _____.
To ensure your visit is as smooth as possible please be sure you have all of the following items when you arrive:

1. Your picture ID
1. All of your insurance cards
2. Any applicable deductible, co-insurance or co-payment
3. Your current medications in their original containers (including over-the-counter)
4. **Completed** enclosed paperwork (please, bring it to the appointment -- do not mail it back)
5. If applicable/ available, any medical records, results, CDs with imaging, videos of spells

Please, note:

1. If the visit is due to an evaluation for a seizure/ spell, bring the witness of the event to the appointment (or have them readily available by phone). This is absolutely crucial for making the correct diagnosis
2. A copy of a power of attorney, healthcare proxy, or legal guardianship documents are required at the time of your appointment if you are signing on behalf of a patient over the age of 18.

If you need to reschedule this appointment, please call our office at least 48 hours prior to the appointment. **There is a $75 no-show fee.**

Again, we thank you for choosing our clinic. We look forward to meeting you.

Sincerely,

The Staff and Physician at
Little Buddies Child Neurology PLLC

# Patient Registration Information

**Patient's Name**: _____

Date of birth: _____ Gender: _____

Address: _____ City: _____ Zip: _____

Primary phone number: _____ Alternative phone number: _____

E-mail address:_____

Marital Status (circle one): Single / Mar / Div / Sep / Wid Occupation: _____

Employer: _____ Language (if other than English):_____

Referring physician: _____ Primary care physician (if different): _____

Pharmacy name: _____ Address: _____ Zip: _____

**Emergency contact's name**: _____

Relationship: _____

Primary phone number: _____ Alternative phone number: _____

**Legal guardian's name (if applicable):**_____

Date of birth: _____ Gender: _____

Address: _____

Primary phone number: _____ Alternative phone number: _____

**Insurance information:** You will need to provide your insurance card to us.

**Primary insurance plan:** _____

Policy No: _____ Group No: _____ Subscriber's name: _____

Subscriber's date of birth: _____ Patient's relationship to subscriber: _____

**Secondary insurance plan:** _____

Policy No: _____ Group No: _____ Subscriber's name: _____

Subscriber's date of birth: _____ Patient's relationship to subscriber: _____

# The following disclosure is required by New York State Surprise Bill:

In the event Dr. Snyder does not participate with your health plan network or if you are a self-pay patient, you are being informed in writing of estimated amount that we will bill for healthcare services provided or anticipated to be provided for non-emergency services:
New patient visit = $240
Follow up visit = $150
EEG = $325
EMG/NCS = $375 (total, not per extremity)

Dr. Snyder participates with the following healthcare plans:
Aetna
Blue Choice Option
Child Health Plus
Cigna
Empire Plan
Excellus/BCBS (most plans – please, verify with your insurance if yours is included; BCBS of Western NY excluded: authorization for every visit required)
Fidelis Care
Lifetime Benefit Solutions
Medicaid
MVP
TRICARE East (authorized non-network participating provider: prior authorization required)
United Healthcare (most plans – please, verify with your insurance if yours is included)
Your Care
*Note: Dr. Snyder is a NONparticipating provider with MediCare and all of its managed plans.

Dr. Snyder has "referrer and follow privileges" at Strong Memorial Hospital which is located at 601 Elmwood Ave., Rochester, NY 14642. This means that, if necessary, she will refer you to be admitted to this hospital. However, the hospital's physicians will be treating you while an inpatient. Dr. Snyder will resume primary treating physician responsibilities upon your discharge from the hospital.

Patient Name (please print): _____ DOB: _____

Patient Signature: _____ Date: _____

# Other Office Policies and Procedures

**Identity Theft Prevention**

The Federal Trade Commissions "Red Flag" rule requires health care providers to establish a program to prevent identity theft. As a result, we will be asking all patients to provide photo identification when checking in for their appointment. If you are unable to provide us with proper identification at the time of your visit, we will need to reschedule your appointment.

**Prescription Refills**

Dr. Snyder will prescribe medications in quantity sufficient to last until the next scheduled appointment – if you are running low on the medications, please call your pharmacy to request a refill. In exceptional circumstances, if the pharmacy does not have an authorized refill on file, please call the office but please allow 5 business days for medications to be filled. Refills requiring a prior authorization take a minimum of 10 days. The patients must be seen in our office, with the frequency dictated by clinical circumstances and determined by Dr. Snyder in order for Dr. Snyder to continue to prescribe these medications since changes in dose or discontinuation may be warranted.

**Limitations to phone call management**

While some simple requests (e.g. to schedule/reschedule an appointment, paperwork got lost in a mail, simple clarifications) are appropriate and will be answered as soon as possible (please, allow at least 24 hours), for safety and better treatment results. Medical management, especially of new problems (e.g. a problem different from the one for which you were initially seen, the need to adjust medications doses, or medication side effects requiring a different medication to be started), all require an in-person follow up visit for determining an appropriate treatment plan and the patient's understanding of it. While Little Buddies Child Neurology PLLC does not offer walk-in visits, you may be worked into the schedule if a need arises.

**Telephone calls**

585-542-9272 is the main clinic number. If you call during normal business hours and the telephone is not answered, we may be with another patient. Please, do *not* call the clinic telephone number with life-threatening emergencies – dial 911 instead. If you leave a voicemail, your call will be returned within 24 hours. Please note, given the high robocall volume, missed telephone calls *without* voicemail will *not* be returned. If you are an established patient with an urgent medical issue that cannot wait until the office opens, please call Dr. Snyder's cell phone number as instructed in the main line voicemail greeting. If the telephone call leads to significant amount of time spent/ medical decisions made, telephone management code will be billed, and the claim will be sent to your insurance (patient responsibility may apply depending on your plan).

**General Consent to Treatment and Right to Refuse Treatment**

By signing below, I (or my authorized representative on my behalf) authorize Little Buddies Child Neurology PLLC and its staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

In giving consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the individual treating healthcare provider. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Patient Name (please print): _____ DOB: _____

Patient Signature: _____ Date: _____

# Financial Policy

We are committed to providing every patient with excellent medical service, including assistance with billing and insurance matters. We want you to completely understand our payment policies. Please read carefully and sign our Financial Policy below:

The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of Little Buddies Child Neurology PLLC fees. You are ultimately responsible for payment of your bill.

1. Insurance: Little Buddies Child Neurology PLLC participates with most major insurance plans. Knowing your insurance benefits is your responsibility. **Due to the increasing complexity of insurance plans, Little Buddies Child Neurology PLLC requires you to contact your insurer's Member Services for information on your coverage and out-of-pocket costs.** Your insurance plan is the best place to find information on the ultimate cost to you. Your insurance carrier can tell you whether Dr. Snyder is in their provider network. Little Buddies Child Neurology PLLC will verify benefits for you, but this is not a guarantee of payment. A copy of your current insurance card is required to provide proof of insurance. If you fail to provide Little Buddies Child Neurology PLLC with the correct insurance information in time to meet your insurance company's claim filing limit, you will be responsible for any charges not paid by insurance.

2. Patients with No Insurance or Coverage with a Non-participating Insurance Plan: Payment for services is expected on the date of the appointment, unless specific payment arrangements are discussed prior to the appointment. Self-pay rate is as following: new patient visit = $240, follow up visit = $150, EEG = $325, EMG/NCS = $375 (total, not per extremity).

3. Co-payments, co-insurance, deductible, non-covered procedures, and services considered "not medically necessary" by your insurance plan must be paid at the time of service. $25 fee will be added to your account if you are unable to pay your co-payment on the day of your appointment or it may have to be rescheduled.

4. Claims Submission: Little Buddies Child Neurology PLLC will submit your claims and assist you in any way we reasonably can to help get your claims paid with the insurance information you have provided us. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not pay your claim in 90 days, the balance will be billed to you.

5. Non-payment: If your account is over 30 days past due, a reminder statement will be mailed. Outstanding personal balances older than 60 days (from the date of service) are considered delinquent and will be transferred to our collection agency (RR Resource Recovery, LLC). A single phone call will be made 3 days prior to transferring the account to the collection agency to the phone number indicated as a contact phone number. **Any collection fees incurred and collection agency charges will be added to your account.**

6. **Missed Appointments:** Failing to keep appointments will pose a health risk to the patient. Little Buddies Child Neurology PLLC asks that patients notify the practice 48 hours in advance if they are unable to keep their scheduled appointment time (including for EEGs and EMG/NCS). We understand that there may be times when you miss an appointment due to emergencies or other obligations. However, patients who fail to provide adequate cancellation notice, **at least 48 hours** prior to the appointment time will be assessed a **$75 no-show fee**. Missing three appointments without notifying the office will result in a patient's discharge from the practice, but medical care will not be withheld if the patient presents with a medical emergency within 30 days of being discharged.

7. Little Buddies Child Neurology PLLC will use any available phone numbers that you have provided us to contact you regarding appointment matters, insurance questions and account balances of any type. Your signature below represents your authorization.

8. Bill pay: For the convenience of our patients, our office accepts Visa, Master Card, Discover, and American Express. Online bill pay is available through www.LittleBuddiesChildNeurology web site. Checks returned to our office for insufficient funds will result in a $15.00 charge to the patient's account.

**Assignment of benefits and release of information:**

I assign all payments for medical services to Little Buddies Child Neurology PLLC. I authorize Little Buddies Child Neurology PLLC to release my medical records and information to any third party payers which will need information to process claims for health care benefits, disability, or for performing quality assurance reviews, as required by law. I also give permission to Little Buddies Child Neurology PLLC to release information to other health care physicians and health care facilities for the purpose of discussing my conditions, consulting on my case, or for coordinating my medical care. I understand that I am financially responsible for charges not covered by my insurance plan, and I hereby guarantee timely payment in full of any such charges. A photocopy of this assignment and authorization is considered as valid as the original. This authorization will remain in effect until revoked in writing.

By signing below, you are acknowledging that you have read and fully understand our Financial Policy above.

Patient Name (please print): _____ DOB: _____

Patient Signature: _____ Date: _____

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# Consent for Telemedicine Services

You understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Little Buddies Child Neurology PLLC providing health care services to you via telemedicine if needed.

You understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit just like when you are seen in the office setting.

You understand that you will be responsible for any copayments, coinsurance, deductibles that apply to your visit, just like when you are seen in the office setting. You understand that regular (in-person) appointments rules apply, including our late arrival, no-show and late cancelation policy. We strongly encourage you to log into the waiting room at least 5 min prior to your appointment time.

You understand that you have the right to withdraw your consent to the use of telemedicine in the course of your care at any time, without affecting your right to future care or treatment. As long as this consent is in force (has not been revoked), Little Buddies Child Neurology PLLC may provide health care services to you via telemedicine without need for us to verbally complete another consent form.

Patient Name (please print): _____ DOB: _____

Patient Signature: _____ Date: _____

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# Patient Credit Card on File Agreement

We have implemented a policy to enable you to maintain your credit card information securely on file with Little Buddies Child Neurology PLLC. In providing us with your credit card information, you are giving Little Buddies Child Neurology PLLC permission to automatically charge your credit card on file for your balances (including but not limited to co-pay, co-insurance, deductible, no show fee, processing fee, medical records copying fee, etc.). By signing this form, you authorize this agreement will remain in effect until the expiration of the credit card account or until you cancel this authorization. To cancel, you must give a 30-day notification to Little Buddies Child Neurology PLLC. in writing and the account must be in good standing. Little Buddies Child Neurology PLLC. will not alter your treatment plan due to possible charges incurred.

Choose the method of the receipt delivery:

◯ E-mail to:_____

◯ Mail to the address on file.

Patient Name (please print): _____ DOB: _____

Patient Signature: _____ Date: _____

# Health Insurance Portability and Accountability Act (HIPAA) Acknowledgement of Receipt of Privacy Notice and Restrictions/Permissions

A copy of Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state laws has been made available to me.
I understand the contents of the Notice and I request the following exceptions:

**Restrictions:**
Please restrict the use and disclosure of my protected health information as follows (write N/A if not applicable):

_____
_____
_____

**Permissions:**
I give permission to the following individuals to view, discuss, exchange, and/or receive my protected health information (include any family members, psychologists, doctors other than the one who referred you here):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This notice and consent will remain in effect unless/until revoked in writing.

Patient Name (please print): _____ DOB: _____

Patient Signature: _____ Date: _____

If signed by a person other than the patient, please indicate relationship: _____

NOTE: Power of attorney, healthcare proxy, or legal guardianship documents are required at the time of your appointment if you are signing on behalf of a patient over the age of 18.

**Please, keep the following**

**Health Insurance Portability and Accountability Act**

**(HIPAA) Privacy Notice**

**For your records**

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## NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability & Accountability Act (HIPAA) of 1996

**WHO WILL FOLLOW THE TERMS OF THIS NOTICE**

• All health care professionals, employees, students, volunteers and other personnel authorized to access your medical record.

**OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION**

We are required by law to:

• Make sure that medical information that identifies you is kept private;

• Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and

• Follow the terms of this Notice.

**HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

The following categories describe different ways that we may use and disclose your medical information:

• Treatment. We may use your medical information to provide you with medical treatment or services. We may disclose your medical information to others who are involved in taking care of you. We may share your medical information (such as x-rays, lab work, prescriptions) with another health care provider to deliver, coordinate, or manage your healthcare.

• Health Care Operations. We may use and disclose medical information about you for health system operations. For example, we may use your information to review our treatment and services, to assess the care and services we offer and to educate health care professionals or trainees.

• Business Associates. We may disclose your health information to contractors, agents and other associates who need information to assist us in carrying out our business operations. Our contracts with them require that they protect the privacy of your health information.

• Appointment Reminders. In the course of providing treatment to you, we may use your health information to contact you (e.g.: by phone or postcard) with a reminder that you have an appointment for treatment or services.

• Health-related Benefits and Treatment Alternatives. We may use and disclose medical information to tell you about or recommend health-related benefits, services or treatment alternatives that may be of interest to you.

• Individuals Involved in Your Care or Payment for Your Care. If you do not object, we may release medical information about you to a friend or family member who is involved in your care or payment for your care.

• Incidental Disclosures. Disclosures of your information may occur during or as an unavoidable result of otherwise permissible uses or disclosures of your health information. For example, during the course of your treatment, other patients in the area may see or overhear discussion of your health information despite using reasonable safeguards.

• Personal Representatives. We may disclose your health information to your personal representative who has authority to act on your behalf under applicable law.

*IN SPECIAL SITUATIONS:

• As Required by Law. We may disclose medical information about you without your authorization when required to do so by federal, state or local law.

• Victims of Abuse or Neglect. We may release your health information to a public health authority authorized to receive reports of abuse or neglect.

• Public Health Purposes. We may disclose medical information about you for public health activities related to prevention or control of disease, injury or disability. For example, we report certain communicable diseases to the Department of Health.

• Health Oversight Activities. We may disclose your medical information to health oversight organizations authorized to conduct audits, investigations, and inspections of our facilities.

• Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order, subpoena or other lawful process.

• Law Enforcement. We may release health information for law enforcement purposes in limited circumstances.

• To Avert a Serious and Imminent Threat to Health or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public.

• Sale of Protected Health Information. We may only sell your protected health information in very limited circumstances without your written authorization, such as if the covered entity is sold.

• Military and Veterans. If you are or have been a member of the armed forces, we may release your medical information as required by the Departments of Defense, Transportation or Veterans Affairs.

• Protective Services for the President and Others. We may disclose health information about you to authorized federal officials for the provision of protective services to the President, foreign heads of state or certain other persons.

• National Security and Intelligence Activities. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities required by law.

**ELECTRONIC HEALTH CARE RECORDS**

Some of your medical information may be created and/or stored in an electronic format. When permissible for valid purposes (e.g., providing treatment or billing for services) your health care providers may access your medical information electronically.

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Receive Copies**. You may ask to inspect and to receive copies of medical information that may be used to make decisions about your care, including your medical and billing records. To inspect or receive copies of your medical information, submit your request in writing to the address on the front page of this notice. We may charge a fee for the costs of copying, mailing or other supplies associated with your request for copies. You may not be denied a copy if you are unable to pay. You may request an electronic copy of your record and it will be provided in an electronic format if it is readily producible; otherwise you will be provided with a

printed copy. We may deny your request to inspect or receive copies in certain limited circumstances. If your request is denied, you may ask that the denial be reviewed. Another licensed health care professional who we choose will review your request and the denial. The person conducting the review will not be the person who denied your request. You have additional rights to appeal a denial to the New York State Department of Health.

**Right to Amend.**

If you feel your medical information is incorrect or incomplete, you may ask to amend the information for as long as we maintain the information. Your request must be made in writing to the address above. You must also provide a reason that supports your request. We may deny your request if the information:

• Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

• Is not part of the medical information kept by or for us;

• Is not part of the information that you would be permitted to inspect or receive copies; or

• Is accurate and complete.

If your request to amend your record is denied, you will have the right to have certain information related to your requested amendment included in your records. These rights will be explained to you in the written denial notice.

**Right to a Listing of Persons Receiving Your Medical Information.**

You may request an "accounting of disclosures" of medical information released about you. An accounting of disclosures does not include disclosures made:

• to you or your personal representative;

• with your written authorization;

• for treatment, payment or health care operations;

• to your family or friends involved in your care or payment for your care;

• incidental to permissible uses or disclosures;

To request this list, submit your request in writing to the address above. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. We may charge you for the costs of providing additional lists. We will notify you of the cost involved and you may withdraw or change your request before you are charged any fees.

**Right to Request Restrictions**.

• You have the right to request restrictions on how we use or disclose your health information to treat your condition, collect payment for your treatment or for our health care operations. We are not required to agree to your request. If we do agree, we will fulfill your request unless the information is needed to provide you emergency treatment. You may direct your written request to the address above.

• You have the right to restrict disclosure of your medical information to your health plan for payment when you make a written request and pay for the service out-of-pocket in full prior to or at the time of the service, or if you make payment arrangements at the time of the service that are complied with in a timely manner. We will comply with this restriction unless the disclosure is required by law.

**Right to Request Confidential Communications.**

You may request that we communicate with you about medical matters in an alternative way or at an alternative location (for example, you may wish to be contacted at work rather than at home). Your request should be directed to the area that would handle the communication. You do not need to provide a reason for your request. Reasonable requests will be accommodated.

**Right to Breach Notification.**

You have the right to be notified of a breach of your unsecured protected health information, with a few limited exceptions. A breach is defined as unauthorized acquisition, access, use or disclosure of protected health information in a manner not permitted, unless there is a low probability that the privacy or security of your protected health information has been compromised.

**Right to a Paper Copy of this Notice.**

You may obtain a copy of this Notice at the Little Buddies Child Neurology website, or you may also request a paper copy of this Notice at the office.

**CHANGES TO THIS NOTICE**

We reserve the right to change this Notice. We may make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The current Notice will be displayed and available to you.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a privacy-related complaint with us, you may call the at 585-542-9272. All complaints to the Department of Health and Human Services must be submitted in writing. You will not be penalized for filing a complaint.

**OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us your authorization to use or disclose medical information about you, you may revoke that permission, in writing, at any time. However, we are unable to take back any disclosures we have already made with your permission. Your health information may also be disclosed to the Secretary of Department of Health and Human Services for the purpose of investigating or determining Little Buddies Child Neurology PLLC compliance with HIPAA. If you have any concerns about the uses of your medical information, please feel free to discuss the issues with your health care provider. If you have questions about this Notice, please call us at (585) 542-9272. If you have any concerns or complaints, you can call Monroe County Medical Society at (585) 473-7573.

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Patient's Name: _____; DOB:_____; Sex: M/F

**ADULT NEW PATIENT VISIT FORM**

Please, fill out this form to help us serve you better.

How old are you? _____ years old

What is your hand preference? ◯ Right-handed ◯ Left-handed ◯ Ambidextrous

Who referred you to us?_____

Why are you being seen?_____

Were you seen by anyone else for this problem previously? YES NO

If yes, who?_____

Did you have any prior testing for this problem? YES NO

If yes, what was done?

| | Test name (e.g. MRI, CT, EEG) | When was it done? | Where was it done? | What did it show? |
|---|---|---|---|---|
| 1 | | / / | | |
| 2 | | / / | | |
| 3 | | / / | | |

Did you have any *prior* treatment for this problem? YES NO

If yes, what?

| | Medication or intervention | Dose | How often? | Did it work? | Any side effects? | Why was it stopped? |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |

Do you *currently* take *any* **medications** (including non-prescription, vitamins, food supplements, special diet, etc.)? YES NO

If yes, what?

| | Medication | Dose | How often | For what indication? |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

Are you involved in any therapies? YES NO

If yes, what? ◯ PT ◯ OT ◯ Speech Therapy

Please, specify any details if applicable_____

Patient's Name: _____; DOB:_____; Sex: M/F

Do you have any **allergies**? YES NO
If yes:

| | What are you allergic to? | What kind of a reaction? |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

Do you *currently* have any other **medical problems**? YES NO
If yes:

| | Illness | Year |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

Did you have any **medical problems** in the *past*? YES NO
If yes:

| | Illness/surgery/admission to a hospital (overnight) | Year |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

As far as you know, were there any issues with you when your mother was pregnant with you or during the delivery? YES NO
Please, specify any details if applicable_____

As far as you know, was your early development normal? YES NO
Please, specify any details if applicable_____

Is there a **Family History** of neurologic problems (including but not limited to: seizures, developmental delays, MR, headaches (even if mild), car sickness, high arch feet/hammer toes, tics, tremors, wheelchair bound, etc.)?
YES NO
If yes, what disorders?

| | Relationship to the patient | Disorder |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

**Social History:**

| | | |
|---|---|---|
| 1 | With whom do you live? | |
| 2 | Where do you work? | |
| 5 | What is your level of education? | |
| 7 | Do you smoke? If yes, how much? | |
| 8 | Do you consume alcohol? If yes, how much? | |
| 9 | Do you use recreational drugs? If yes, what? If yes, how much? | |

Patient's Name: _____; DOB:_____; Sex: M/F

**Review of Systems:**
Do you have any of the following problems? (Circle for YES below) NO

1. Constitutional: poor appetite, fevers, night sweats, unintentional weight loss, fatigue
2. Neurological: numbness, tingling, headache, car sickness, seizures
3. Eyes: wearing glasses, changes in vision, eye pain
4. Ear/nose/throat: hearing difficulties, ear pain, dry mouth, feeling that the world is spinning
5. Cardiovascular: irregular heartbeat, lightheadedness, ankle swelling, "passing out"
6. Respiratory: cough, wheezing, shortness of breath
7. Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea
8. Urinary: kidney stones, pain during urination, incontinence
9. Genital/reproductive: being sexually active, heavy or irregular periods, pregnancy
10. Muscular-skeletal: scoliosis, neck or back pain, indented chest wall, joints too loose
11. Skin: birth marks, rashes, moles, dry skin, sensitivity to sun light
12. Psychology/psychiatry: sadness, tearfulness, fears, ADHD, hallucinations, difficulty sleeping
13. Endocrine: excessive thirst, heat intolerance, diabetes, thyroid or growth problems
14. Hematologic: easy bleeding/bruising, swollen nodes
15. Immunologic: allergic reactions, skipped vaccinations
16. Pain: On a scale of 0-10 (0 = no pain; 10 = worst pain imaginable), how would you rate it? _____

What do you hope to achieve from this visit? _____

_____

Patient's signature: _____ Date _____

Thank you!

---

**OFFICE USE ONLY**

Dr. Snyder _____ on _____