Melissa Przeklasa Auth, M.D.
30131 Town Center Drive Suite # 237
Laguna Niguel, CA 92677
Office: (949) 495-6100
Fax: (949) 354-0612
occhildneurology.com

Patient Demographic Information

PLEASE COMPLETE IN BLACK INK

Patient Name:	Date of Birth:

Today's Date: _____Age: _____ Sex: _____

Child's Legal Guardian: Mother _____ Father _____ Other: (specify)_____

Parent/Guardian's Name:_____

Parent/Guardian's Occupation: _____

Parent/Guardian's Cell Phone: (_____) _____ Date of Birth: _____+___

Parent/Guardian's Email Address: _____

Parent/Guardian's Name: _____

Parent/Guardian's Occupation: _____

Parent/Guardian's Cell Phone: (_____) _____ Date of Birth: _____

Parent/Guardian's Email Address: _____

Patient's Home Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____

Alternate Home Address:_____

City: _____ State: _____ Zip Code: _____

Child's Primary Care Physician: _____

Physician's Phone Number: (_____) _____

Physician's Fax Number: (_____) _____

Pharmacy Name: _____

Pharmacy Phone Number: (_____) _____

Pharmacy Fax Number: (_____) _____

Who has referred this child: _____

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Parent Questionnaire

*PLEASE COMPLETE IN **BLACK INK***

Patient Name:	Date of Birth:

Form Completed By: Mother ☐ Father ☐ Other: _____

Referring Physician: _____

Child Profile

What concerns do you have about your child: (please a brief summary of the main concerns)?
When were the problems first noticed? Have they progressed? How have they been handled so far?

What has your child been told about coming for this evaluation?

Past/Current Treatment History

Please list or describe any chronic medical problems (asthma, diabetes, developmental delays, etc).
Please describe any major illnesses, surgeries, or hospitalizations.

Is your child currently taking any medications (including supplements/vitamins)? No ☐ Yes ☐ If yes, specify:

Does your child have any allergies? No ☐ Yes ☐ If yes, specify:

Are your child's immunizations up to date? Yes ☐ No ☐ If no, please explain:

Has your child had vision and hearing screening performed either by your physician at the school? If yes, please specify when, by whom and results:

Has your child had previous neurological, developmental/behavioral, psychological, or psychiatric evaluations and/or treatment (e.g., medication, counseling, tutoring, speech, physical or occupational therapy, not described above and by whom?

Patient Name:	Date of Birth:

Birth History

Was your child born two or more weeks before the "due date"? No☐ Yes ☐

If yes, how many weeks early was your child born? _____ weeks early

How much did your child weigh at Birth _____

Biological Father's age at birth of your child _____ Biological Mother's age at birth of your child _____

Number of pregnancies prior to this child _____ Number of miscarriages prior to this child _____

Were there any problems during the pregnancy, labor/delivery or following the birth? No ☐ Yes ☐

If yes, please specify:

Was your child born by C-Section? No ☐ Yes ☐

If yes, please specify why:

Were any substances or medication used by the mother during the pregnancy? No☐ Yes☐

If yes, please specify (e.g., prescription medication, alcohol, tobacco, etc.)'

Developmental History:

(Please *write in* age. Ages in *parenthesis* are *approximate normal limits.)*

***Check this box and skip the following history if all milestones were on time*:** ☐

Gross Motor:	***Fine Motor:***
Rolled over (4-5 mos) _____ Sat without support (6-7 mos) _____ Walked alone (12-16 months) _____ Runs (15-18 mos) _____ Catches a ball (3 years) _____ Hops on one foot 2-3 times (4 years) _____	Copies circle (3 years) _____ Copies Square (5 years) _____ Adaptive /Self help: Drinks from a cup (12 – 15 mos) _____ Uses a spoon (15-24 mos) _____ Undresses completely (3 years) _____ Dresses Completely (4 years) _____
Language Development:	***Social/Emotional Development***
Babbles (6 mos) _____ Understands "NO" (9-10 mos) _____ 3-5 word vocabulary (12 mos) _____ Follows 1 step command with gestures (12 mos) _____ Can point to several body parts (16-17 mos) _____ 2-word phrases (24 mos) _____ Follows 2 step command (24 mos) _____ 3 word sentences (3 years) _____	Temperament as a baby (e.g. easy, colicy): Shy with strangers (7-8 mos) _____ Plays cooperatively with peers (4 yrs) _____ Current temperament/mood (e.g. irritable, anxious, happy):

Are there any current problems or concerns with development not mentioned already?

Patient Name:	Date of Birth:

Patient **Review of Systems**

Has your child had any problems mentioned below that you haven't already described?

	Y	N	Explain
Weight loss or gain			
Weakness			
Rash			
Itching			
Light or dark skin color changes			
Changes in hair growth or loss			
Headaches			
Double vision			
Neck stiffness or pain			
Chest pain			
Palpitations			
Fainting/passing out			
Heart murmurs			
Shortness of breath			
Wheezing			
Appetite changes			
Indigestion/reflux			
Nausea, vomiting or diarrhea			
Recent changes in bowel habits			
Change in urinary frequency			
Bed wetting			
Problems with menstruation			
Joint pain, swelling or redness			
Convulsions			
Staring spells			
Tremor			
Incoordination (ataxia, tremor)			
Anxiety / Depression			
Anemia			
Bleeding Tendency			
Previous Blood Transfusions			
Lymph node enlargement or tenderness			

Patient Name:	Date of Birth:

Family **Medical History (*other* than patient)**

Please include all pertinent ***FAMILY history*** for first and second-generation ***FAMILY members***.

	Y	N	***Family*** **Member's relationship to child**
Trouble learning to read			
Trouble with arithmetic			
Trouble with writing			
Attention Deficit/Hyperactivity disorder			
Other school problems			
Speech problems			
Language delay			
Behavior problem in childhood			
History of physical or emotional abuse			
Depression			
Anxiety/Phobia/panic disorders			
Other Mental illness			
Drinking problems			
Drug Abuse			
Seizures			
Mental Retardation			
Autism			
Headaches/Migraines			
Tourette Syndrome			
Neurologic Conditions			
Congenital Anomalies			
Diabetes			
High blood pressure			
Irregular Heartbeat or rhythm			
Heart attack before 40 years old			
Thyroid condition			
Deafness			
Blindness			
Any other disorders in the family			

Patient Name:	Date of Birth:

Social history

Child's School: _____ City: _____

Teacher's Name: _____ Grade: _____

Type of Classroom: Regular ☐ RSP ☐ Special Day Class _____

IEP/504:_____

This child is currently living with:

☐ Biological mother and biological father

☐ Biological mother

☐ Biological father

☐ Adoptive parents. Is your child aware that he/she is adopted? _____

☐ Foster parents

☐ Other (specify) _____

The biological parents of this child are currently:

☐ Married to each other (Years married: ___)

☐ Divorced from each other

☐ Separated from each other

☐ Never married to each other

Please list all people who are currently living in this child's household (name, age, and relationship to child):

Name	Age	Relationship

Other Concerns

Are you concerned about issues not covered in this questionnaire? Please describe:

Thank you for completing this questionnaire. It will be reviewed as a valuable first step in evaluating your child.

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Patient Name:	Date of Birth:

Financial Agreement 2024

I understand that Dr. Przeklasa Auth is an "in-network provider" for Monarch HealthCare HMO, Mission Hospital Allied Physicians HMO, Cigna PPO, Anthem Blue Cross PPO, Blue Shield of California PPO, and United PPO. For all other insurance plans I understand that Dr. Przeklasa Auth is an "out-of-network provider" and I am financially responsible for all charges incurred for services rendered. Your insurance company requires us to collect co-payments, coinsurance, and/or deductible amounts at the time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Once we receive your insurance Explanation of Benefits, if there is any outstanding balance we will notify you of the amount and automatically charge the below credit card within 48 hours. Any "no shows" or cancellations with less than 24 hours notice will incur a fee equivalent to the scheduled appointment $500 for a new patient appointment and $200 for a follow-up appointment. If your insurance changes, please notify us prior to your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Person Financially Responsible:

Name:_____

Cell Phone: (_____) _____

Email Address: _____

Home Address:_____

City:_____ State:_____ Zip Code: _____

Credit Card Authorization Visa and Mastercard ***ONLY***. We do not take American Express.

Card Type (Circle): ☐ VISA or ☐ MASTERCARD

Name on Card: _____

Card Number: _____

Home Address: _____

Verification Code: _____

Expiration Date: _____

_____

Signature

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Patient Name:	Date of Birth:

Authorization to Consent to Treatment of a Minor

I, the undersigned parent to:_____ , a minor, do hereby authorize Melissa Przeklasa Auth, M.D., as agent for the undersigned to consent to any examination, medical diagnosis or treatment which is deemed advisable and to be rendered at the office.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian

Special Letters, Forms, and Prescriptions

I understand that if I request a letter written or a form completed, describing any medical conditions and/or treatments, I will be charged a fee of $25 for this service. Any medication changes or prescriptions requested in between visits, I will be subject to a $25 charge. Controlled substance prescriptions will only be sent electronically.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian

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Medication Policy

Effective December 1, 2022

Dr. Przeklasa will provide you with enough medication until your next follow-up appointment. Your child will need to be seen in the office for follow-up visits until he or she is stable on the medication. Frequent follow-ups are necessary in the beginning stages to assess for any side effects and to assist with adjusting the medication to find the proper dosage. Once your child is stable on medication, office visits will typically be spaced out to every 4-6 months.

With regard to stimulant medications, they are strictly controlled by the DEA. The original prescription must be sent electronically under controlled procedures in order to be filled. These medications are only written for a 30-day supply without refills.

Any medication refills, changes, or lost prescriptions requested, in between visits, will be subject to a $25 charge.

If your insurance requires a prior authorization for medication, it can take up to seven business days. All prior authorizations are performed on Mondays and Thursdays. Please be sure that your pharmacy sends us the required documentation, we cannot proceed with a prior authorization without the appropriate pharmacy codes.

Thank you for your cooperation.

Patient Name: _____

Parent Name: _____

Date: _____

Parent Signature: _____

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Patient Name:	Date of Birth:

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Melissa Przeklasa Auth, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Melissa Przeklasa Auth, M.D. describes such uses and disclosures more completely.)

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available in the reception area, and that a copy of any amended Notice of Privacy Practices is also available on this medical practice's website.

Melissa Przeklasa Auth, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Office Manager; 30131 Town Center Drive # 237; Laguna Niguel, CA 92677; (949) 495 - 6100.

With this consent, Melissa Przeklasa Auth, M.D. may call, mail or email my home or other alternative location (including leaving a message on voice mail) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Melissa Przeklasa Auth, M.D. may use my PHI for continuity and coordination of my treatment. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Our office may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

I have the right to request that Melissa Przeklasa Auth, M.D. restrict how she uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Melissa Przeklasa Auth, M.D. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Melissa Przeklasa Auth, M.D. may decline to provide treatment to me.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian Date

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ImPACT Demographic Information

PLEASE COMPLETE IN BLACK INK

Patient Name:	Date of Birth:

School / Organization: _____

Height: _____ft _____in Weight: _____ Gender: _____ male _____ female

Handedness: _____ right _____ left _____ ambidextrous (both right and left)

Native Country / Region: _____

Native Language: _____

Second Language: _____ (only if fluent in speaking and writing)

Years of education completed excluding kindergarten: _____ (e.g., high school senior is 11 years)

Check any of the following that apply:
☐ Received speech therapy
☐ Attended special education classes
☐ Repeated one or more years of school
☐ Diagnosed attention deficit disorder or hyperactivity
☐ Diagnosed learning disability

While in school, what type of student were / are you?
☐ Below Average ☐ Average ☐ Above Average

Current Sport: _____

Current position / event / class: _____(e.g., quarterback, forward, 1st base, etc.)

Current level of participation: _____(e.g., junior high, high school)

Years of experience at this level: _____ (0 - 4) (e.g., number of years in high school, high school senior = 3)

Please list your 5 most recent concussions: _____ month _____ year
_____ month _____ year
_____ month _____ year
_____ month _____ year
_____ month _____ year

Concussion History

_____ Number of times diagnosed with a concussion (excluding current injury)

_____ Total number of concussions

_____ Total number of concussions that resulted in confusion

_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately after injury

_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately before injury

_____ Total number a games that were missed as a direct result of all concussions combined

Indicate if you have had any of the following:

_☐_ yes _☐_ no Treatment for headaches by physician
_☐_ yes _☐_ no Treatment for migraine headaches by physician
_☐_ yes _☐_ no Treatment for epilepsy / seizures
_☐_ yes _☐_ no Treatment for brain surgery
_☐_ yes _☐_ no Treatment for meningitis
_☐_ yes _☐_ no Treatment for substance abuse / alcohol abuse
_☐_ yes _☐_ no Treatment for psychiatric condition (depression, anxiety)

Have you been diagnosed with any of the following?
_☐_ yes _☐_ no ADD/ ADHD
_☐_ yes _☐_ no Dyslexia
_☐_ yes _☐_ no Autism

Have you participated in any strenuous exercise and/or exertion in the last 3 hrs?
_☐_ yes _☐_ no

Date of your last concussion: _____ month _____ date _____ year

Number of hours slept last night: _____ (approximate if uncertain)

Please list any PRESCRIPTION medication (s) you are currently taking:

_____

_____

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Headache Diary

Patient Name:	Date of Birth:

Date	Time (Start/Finish)	Preceding Symptoms	Intensity (1-10)	Quality of pain	Associated Symptoms	Medication (dosage)	Treatment Response	Triggers

KEY: Preceeding Symptoms: Aura/prodrome of nausea, flashing lights, halos, etc.
Quality of pain: Throbbing, dull ache, sharp/stabbing, etc.
Associated Symptoms: Nausea, vomiting, sound sensitivity, etc.
Treatment Response: Good/fair/poor relief
Triggers: Strong odor, poor sleep, specific food, etc.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

I hereby authorize: _____
DOCTOR/HOSPITAL

_____
ADDRESS

_____
PHONE NUMBER/FAX NUMBER

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE FROM/TO:

MELISSA PRZEKLASA AUTH, M.D.

30131 Town Center Drive Suite # 237, Laguna Niguel, CA 92677
Office: (949) 495-6100 Fax: (949) 354-0612

The medical information/records will be used for the following purpose: _____
This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis & Treatment)
[ ] Limited to the following medical information:_____

I also consent to the specific release of the following records:
Genetic Information _____(initial)
Drug/Alcohol/Substance Abuse_____(initial)
HIV Diagnosis/Treatment _____(initial)
Tests for Antibodies to HIV _____(initial)
Psychiatric/Mental Health _____(initial)

DURATION:
This authorization shall be effective immediately and remain in effect until: _____

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.
PATIENT'S NAME: _____DATE OF BIRTH: _____
ADDRESS: _____
PHONE NUMBER: _____

Signature of patient *or legal/personal representative*: _____
Relationship *if other than patient:* _____

DATE: _____