Lake Norman Neurology
Piedmont HealthCare

CRAIG DUBOIS, M.D. -ANDREW BRAUNSTEIN, D.O. -RYAN CONRAD, M.D. –DOUGLAS JEFFERY, M.D.

124 Professional Park Dr.Suite A
Mooresville, NC 28117

340 Signal Hill Dr. Suite C
Statesville, NC 28625

9735 Kincey Av. Suite203
Huntersville, NC 28078

Phone for all locations: 704-662-3077

Welcome to Lake Norman Neurology. We look forward to seeing you for your appointment. In order to help us serve you better and to ensure that your first visit and all subsequent visits with us go as smoothly as possible, we are providing you with some information and some specific instructions.

About the Practice: This practice is limited to consultaton regarding the diagnosis and treatment of neurological disorders. We do not do any primary care work. So it is important for you to plan to continue to see your family doctor for your other illnesses and needs.

- We are available outside of office hours for emergencies only. If you should have a problem or question outside of business hours please leave a message on our answering machine and we will return your call when the office reopens.
- If you have an emergency outside of office hours you may call 704-662-6052 and leave a message for the doctor on call, call your family doctor or go to the emergency room.
- Our doctors will not fill any narcotics or controlled substances after hours or on weekends.
- An appointment will be required for forms to be filled out. This ensures that you will be available to answer any questions your physician may have and that your form will be filled out promptly and correctly. Without an appointment there is a 25.00 fee.

About our Office Staff: When you arrive at our office, please check in at the desk. We will need your medical history form,patient information sheet and current medication list. We will also make a copy of your insurance card and collect your copay.

What the Doctor Will Do: Before he sees you, he will review your medical records that you brought with you or have had sent to us. When he sees you, he will ask you to tell him in detail about your symptoms, the course of your illness, and what tests and treatment you might have had.
The doctor will ask you many questions to help him understand your problem. He will carefully examine you and then discuss a possible diagnosis, any further tests that might need to be done, and outline a treatment program for you.

What You Are to Bring with You:

1. Any records or radiology reports that pertain to the problem you are seeing us about. You may want to request that other doctors who have seen you for this problem send us copies of their records, lab reports and radiology reports. If you have discs of your studies please bring them with you. This will save time and prevent needlessly repeating tests.

2. Insurance, Medicare and Medicaid cards and insurance referral if appropriate. As a courtesy we will file with primary and secondary insurance carriers. We require your co-payment, deductible or estimated portion at the time of your visit. It is your responsibility to make sure the physician is a provider with your insurance plan. All patient's who are currrently without insurance will need to pay full payment at time of visit. Medical history, patient information and medication forms – filled out completely as you can.
3. Most importantly, bring yourself – on time, **you may be asked to reschedule if you are more than 15 minutes late for your appointment**. We spend as much time as necessary with each patient, occasionally a few minutes more than were scheduled. Usually we can catch up. However, if you are late, you may throw the whole schedule off for everyone else. We urge you to be on time.
4. If for any reason you cannot keep your scheduled appointment time, please give at least 24 hours notice. If not, you will be charged for the visit. We will confirm your appointment time with you in advance.

Pleae feel free to call us if you have any questions. We look forward to seeing you.

Sincerely,

The Staff of Lake Norman Neurology

Piedmont Healthcare Patients:

Piedmont Healthcare is now collecting information from patients during their office visit as part of the Meaningful Use healthcare initiatives put in place by the Federal Government. Listed below is the information that we are gathering to comply with the new program. If you would please take a moment to answer the following questions then hand this paper back to the front desk.

We thank you in advance for your time.

Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity

This classification provides a minimum standard for maintaining, collecting, and presenting data on race and ethnicity for all Federal reporting purposes. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies.
(http://www.whitehouse.gov/omb/inforegstatpolicy/#dr).

1. Which of the following do you consider yourself? (Ethnicity)

_____ Hispanic or Latino _____ Not Hispanic or Non-Latino _____ Not Reported

_____ Declined _____ Unknown

2. Which category best describes your race?

_____ Not Reported_____ African American_____ American Indian, Alaska Native ____Asian
_____Caucasian____Chinese _____ Chuukese ____Filipino _____Guamanian
_____Japanese_____Korean____Kosrean _____ Native Hawaiian_____ Pacific Islander
_____Paluan _____Pohnpeian _____Samoan_____Vietnamese_____ Yapese _____Other
_____Declined

3. Which language do you prefer to use to communicate?

_____ English _____Chinese _____ French _____ Japanese
_____ Spanish _____ Korean _____ Vietnamese

4. What communication method would you prefer the office to use when conveying medical information?

_____ Postal Service (Mailing) _____ Cell Phone _____Home Phone _____ Work Phone

_____ Patient Portal (i.e. FollowMyHealth) this is an electronic way to store and maintain health and fitness information.

Lake Norman Neurology
Piedmont HealthCare

PATIENT ACKNOWLEDGMENT FORM

Patient Name:_____ Date of Birth:_____

Do you want to give authorization for other family members to have access to your medical information?

_____ Yes, I do want to give authorization to the following individual.

NAME: RELATIONSHIP: PHONE:

1._____

2._____

3._____

_____ Yes, I give permission to leave information on my answering machine.

Phone Number: _____

_____ No, I do not want to give anyone authorization to have access to my medical information.

Signature _____

Date: _____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF PIEDMONT HEALTHCARE'S PRIVACY PRACTICES

My signature below indicates that I have received a copy of PHC "Patient Privacy Rights Notice"

Patient or legally authorized individual signature:_____ Date:_____

Relationship to patient:_____

Lake Norman Neurology
Piedmont HealthCare

PATIENT INFORMATION SHEET

Patient name: _____
(first) (middle) (last) (date of birth)

Patient Address_____ Home Telephone# _____

Mobile Telephone# _____

_____

Emergency Telephone# _____

Social Security:_____ Name &Relationship_____

Patient Sex: Male Female Patient Marital Status: Married Single Other

Email Address: _____

Primary Care Physician: _____ Referring Physician:_____

PHARMACY NAME & LOCATION: _____

Reminder calls /Test result calls Preference please circle: Cell Home

May we leave a message: Yes No

Insurance: _____ ID#_____

Insurance Holders Name: _____
(first) (middle) (last) (date of birth)

Insurance Holders Address: _____Phone: _____

_____Patient Relationship: Self – Spouse – Child – Other

Insurance Holders Employer: _____ Employer Phone:_____

Employers Address:_____

I hereby authorize Piedmont HealthCare to release information concerning my medical or surgical treatment to any insurance carrier, including Medicare and Medicaid. I further authorize payment being made directly to Piedmont HealthCare for my insurance benefits including major medical insurance. I understand that I am financially responsible to PHC for my charges and that the filing of insurance does not relieve me of this obligation. I further authorize any payment made by insurance companies that are incorrect to be refunded to the insurance company. I consent to x-ray examinations, laboratory procedures and other medical treatment as recommended by my physician as provided by authorized personnel of Piedmont HealthCare. I also understand that Piedmont HealthCare is not responsible for any of my personal or valuable items I bring with me.

Signature (seal) _____ Date:_____

Lake Norman Neurology
Piedmont HealthCare

MEDICAL HISTORY

Full Name:_____Date:_____

Age:_____Birth Date:_____ Height___ Weight___ Occupation:_____

How you heard about us? Referred by Dr._____Print_____Patient____ Other_____

Family Doctor:(name &address)_____

Marital Status:_____Single ____Married ____Separated ____Divorced ____Widowed

Handedness:____Right ____Left

What problem would you like us to solve? _____

_____

Personal Habits

Do you smoke? __No__Yes __Pipe __Cigars __Cigarettes Daily Amt.? ____pks

Do you drink alcohol? __No __Yes Daily Amount:_____ How long?_____

Do you drink beer? __No __Yes Daily Amount:_____ How long? _____

Do you drink coffee? __No __Yes Daily Amount:_____ How long? _____

Do you drink tea? __No __Yes Daily Amount _____ How long? _____

Do you drink caffeinated soft drinks? __No __Yes Daily Amount:____ How long?____

Past Medical History

List any operations you have had including dates:

_____

List any other hospital admissions, dates, and diagnoses:

_____

Other serious illnesses(not requiring hospitalization) with dates:

_____

List any serious injuries you have had including dates:

_____

Check if you have had: __Heart Attack __High Cholesterol __Diabetes __High Blood Pressure __Thyroid Trouble __Stroke
Other medical history:

_____

_____

Family History

Father Age: Age at death: Cause of death:

Mother Age: Age at death: Cause of death:

Check if any Blood Relative has had: __Snoring __Heart Trouble __Diabetes __Migraine Headaches __Cancer __Nervous Breakdown __Kidney Disease __ HighBlood Pressure __Stroke __Your problem

REVIEW OF SYSTEMS: Check YES or NO for each question or check all that apply

Do you now or did you in the past have trouble with:

HEADACHES: __No __Yes

a. How often? __Daily __Weekly __Monthly __ Other
b. Major Pain: __Front __Back __One Side __All Over __ Other
c. When did headaches first begin? _____
d. Do they wake you from sleep? __Never __Sometimes __Other
e. With headaches? __Nausea __Blurred Vision__Lost Vision __Vomitting __Spots before eyes __Numbness

---

__PASSING OUT __FAINTING __CONVULSIONS __SEIZURES

a. How often? __Daily __Weekly __Monthly __Other
b. When in the day do the spells usually occur? _____
c. Do you: __Fall __Get Stiff __Bite Tounge __Shake __Jerk __Turn Blue __Make Noise __Lose control of kidneys

---

TROUBLE WITH EYES: __No __Yes

a. Sudden Blindness in one eye for 5-10 minutes: __No __Yes (__Right __Left)
b. Double Vision: Objects are separated __Up __Down __Sideways
c. Lid droops: __Left __Right __Both
d. Do you wear glasses or contact lenses? __No __Yes

HAVE YOU EVER HAD THESE PROBLEMS?

a. Sudden loss of use for 5-10 minutes of: __Arm __Leg (__Right __Left)
b. Sudden loss of speech or ability to understand for 5-10 minutes: __No __Yes
c. Been numb in: __Arm __Leg (__Right __Left __Both)
d. Had trouble with (check all that apply): __Saying words __Thinking of words __Concentrating __Thinking __Memory __Pronouncing words
e. Had trouble with __Walking __Tremors __Coordination __Claustrophobia

---

__No problems with anything listed in this section

DIFFICULTY WITH: __Breathing through the nose __Eating __Drinking __Tasting __Hoarseness __Swallowing __Chewing __Smelling __Choking __None of these things

TROUBLE WITH HEARING: __No __Yes

a. Noises or ringing in the ear: __Right __Left
b. Loss of hearing: __Right __Left __Both How long? _____

STOMACH TROUBLE: __No __Yes

__Poor Appetite __Vomiting Blood __Stomach Pain __Nausea __Blood in Stool __Change in bowel habit __Hemorrhoids __Diarrhea __Liver Trouble __Ribbon-like stools __Ulcers __Constipation __Black stool

TROUBLE WITH KIDNEYS & GENITAL ORGANS: __No __Yes

__Getting up more than once per night to urinate __Loss of kidney control __Prostate trouble __Dribbling __Trouble starting kidneys __Impotence __Kidney stones __Voiding frequently __Bedwetting __Menstrual Problems

TROUBLE WITH BACK, NECK OR JOINTS: __No __Yes

a. Back Pain: __Worse with Cough __Worse with Sneeze __Going into legs (_Right _Left _Both) How Long? _____
b. Neck pain: __Going into arms __Going into fingers (_Right _Left _Both) How long?_____
c. Swollen or Tender joints? __No __Yes – Which joints_____

TROUBLE WITH SKIN: __No __Yes __Rash __Lumps __Birthmarks __Other:_____

HAVE YOU RECENTLY: __Lost weight __lbs. __Been depressed __Had crying spells __Gained weight __lbs. __Been nervous __Had night sweats

SLEEP HISTORY: Do you or have you been told you: __Snor/gasp when asleep __Loud snoring __Breathing stops, struggle for breath __Tossing, turning, thrashing __Fall asleep at work or school __Wake feeling unable to move/paralyzed __Morning headaches __Difficulty falling asleep __Excessive sleepiness during the day __Weird dreamlike state while awake __ Frequent awakening __ Legs feel jumpy/jerky.

Lake Norman Neurology
Piedmont HealthCare

Medication/Allergy List

Print Name: _____ Date of Birth: _____

Medication	Strength	Directions

Allergies & Reactions:_____

_____

_____ _____

Signature Date