Tennessee Valley Pediatric Surgery

James C. Gilbert, MD, FACS, FAAP

Zaria Murrell, MD, FACS

Stephanie Drieling, CRNP

Dear Families,

Welcome to Tennessee Valley Pediatric Surgery at Huntsville Women's and Children's Hospital. We understand that "your child needs surgery" are some of the most frightening words any parent ever hears. Faced with the prospect of your child's surgery, you need information and you want an experienced surgeon. You also want to know that your child is receiving compassionate care and that the healthcare providers are working as a team.

Our office works closely with other programs and services throughout the Hospital – including Pediatrics, Anesthesiology, Critical Care Medicine, Radiology, Gastroenterology, Neonatology and Surgery to provide integrated care for your child.

Our staff knows that while they see many patients each year, this may be the first time your child has needed surgery. We will reassure and provide you and your child all the resources needed to successfully navigate your experience.

Enclosed are the patient registration information forms and an appointment card for your child's initial consultation appointment. **Please complete** the patient registrations forms and bring them with you to your appointment. You will also need to bring **a parent or guardian photo ID, your insurance card, list of all medications that your child is currently taking, and legal guardian documentation if applicable and your insurance co-payment**. If no insurance card is provided we will have to list you as a "self pay" patient until the card is presented to us and payment will be due at time of service.

Please be advised a parent(s) or legal guardian MUST be present for the initial consultation appointment. Otherwise, we will not be able to appropriately discuss the potential risks, benefits and/or alternatives to the recommended treatment plan.

If you are unable to keep your appointment or accompany your child please call us as soon as possible to reschedule, before your scheduled appointment time, to ensure you will not be charged **$25 for not keeping your appointment**.

Thank you for trusting us with your child's care. Please let us know what we can do to help make this time less difficult for you.

Sincerely,

James Gilbert, MD
Zaria Murrell, MD

Please call our office to confirm your appointment upon receiving this paperwork.

910 Adams Street,
Ste. 220
Huntsville, AL 35801
o: (256) 265-1800
f: (256) 265-1801

Patient name | DOB | Chart # | Date

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REVIEW OF SYSTEMS HEALTH QUESTIONNAIRE

By answering these questions, you will provide for us a more complete medical history of your child. These pages are considered part of his/her permanent medical record. Please answer as completely and honestly as possible.

Was he/she born on time? Yes / No Weight: _____lbs _____oz

Were there any complications with his/her birth? Yes / No Natural? Yes / No C-section? Yes / No

Were there any complications with the mother's pregancy? Yes / No

Were there any problems with his/her nursery stay? Yes / No

Are his/her shots up-to-date? Yes / No

Has your child ever had a bad reaction to medicine or food? Yes / No

HAS YOUR CHILD HAD ANY RECENT PROBLEMS WITH ANY OF THE FOLLOWING?

Cardiovascular
- ☐ Chest pain and/or pressure
- ☐ Awoke breathless at night
- ☐ Accelerated heartbeat
- ☐ Cold and/or blue hands/feet

Pulmonary
- ☐ Cough with sputum and/or blood
- ☐ Shortness of breath
- ☐ Sleep apnea and/or loud snoring
- ☐ Asthma
- ☐ Frequent colds

ENMT
- ☐ Sore throats
- ☐ Earaches
- ☐ Dizziness
- ☐ Ear infections
- ☐ Nose bleeds
- ☐ Difficulty swallowing

Constitution
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Fever
- ☐ Night sweats

Nervous
- ☐ Headaches
- ☐ Faints/blackouts
- ☐ Seizures
- ☐ Limp
- ☐ Tremors
- ☐ Paralysis
- ☐ Poor vision

Alimentary
- ☐ Abdominal pain and/or discomfort
- ☐ Bloating/distention
- ☐ Nausea/vomiting
- ☐ Incontinence
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gastric reflux

Psychiatric
- ☐ Attention deficit
- ☐ Hyperactivity disorder
- ☐ Learning disability
- ☐ Sleepwalking
- ☐ Difficulty sleeping

Genitourinary
- ☐ Bed wetting
- ☐ Blood in urine
- ☐ Genital rash, lumps

Endocrine
- ☐ Sweating
- ☐ Fatigue
- ☐ Hand trembling
- ☐ Neck swelling
- ☐ Skin, hair, voice changes
- ☐ Thirst

Integumentary
- ☐ Itchy skin
- ☐ Rashes

Hematological
- ☐ Excessive bleeding
- ☐ Lumps under arms, neck, loin
- ☐ Clots in legs, lungs
- ☐ Easy bruising
- ☐ Anemia

Rheumatiod/ Musculoskeletal
- ☐ Joints: pain, stiffness, swollen
- ☐ Variation in joint pain during the day
- ☐ Fingers painful/blue in cold

☐ **Other**: _____
_____
_____

Female patients only:
Experienced menses?
Yes / No
Age of first menses _____
Date of LMP _____

Is the patient a smoker? Yes / No Drug use? Yes / No Alcohol use? Yes / No

Does anyone in your home use tobacco products? Yes / No

Who lives in your home (i.e. mom, grandmother, 2 yr old brother) _____

_____

_____

Are his/her parents in good health? Yes / No Are his/her siblings in good health? Yes / No

Family History

Please complete this information about your child's family history dating back to your child's grandparents.

	Relationship		Relationship
☐ Severe reactions to anesthesia		☐ Diabetes	
☐ Heart disease before age 60		☐ Cancer	
☐ Malignant hyperthermia		☐ Sudden Infant Death Syndrome (SIDS)	
☐ Anemia or bleeding disorders		☐ Asthma	
☐ Kidney disease		☐ Seizures	
☐ High cholesterol		☐ Bowel disease	
☐ High blood pressure		☐ Hereditary disease	

Current Medications

Name	Dosage	Frequency	Prescribing physician

Form completed by _____ Relationship to patient _____ Date / Time _____

Reviewed by _____ Date / Time _____

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PLEASE PRINT

PATIENT INFORMATION

Date _____

Patient's name _____ D.O.B. ____/____/____
Last First MI

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

SSN ____-____-____ Sex M F

Parent information

Mother's name _____ D.O.B. ____/____/____ SSN ____-____-____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Employeer _____ Employer address _____

Father's name _____ D.O.B. ____/____/____ SSN ____-____-____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Employeer _____ Employer address _____

Pediatrician / primary care physician information

Physician name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Referring physician (if different) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency contact information

In case of emergency, notify _____ Relationship _____

City _____ State _____ Phone _____

If patient is a minor: list persons, other than responsible party on previous page, who have permission to bring child to office for treatment:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Foster child information

Case worker _____ Phone _____

Date of child's placement in your care _____

Circumstances of child's placement into foster care _____

_____

_____

If birth parents call, may we give out information? ☐ Yes ☐ No, refer them to _____

Primary insurance to file

Policy # _____ Group # _____

Insured's name _____ Relationship to patient _____

Insured's social security or I.D. # _____ Insured's date of birth _____

Insurance Company Name _____

Secondary insurance to file

Policy # _____ Group # _____

Insured's name _____ Relationship to patient _____

Insured's social security or I.D. # _____ Insured's date of birth _____

Insurance Company Name _____

Person responsible for this account _____

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency, I will be responsible for all collection fees, court costs and attorney's fees. I authorize Tennessee Valley Pediatric Surgery to release information to insurance carriers and for insurance carriers to release information to Tennessee Valley Pediatric Surgery concerning my illness, treatment and payments. I hereby assign to the physicians all payments for medical services rendered to myself or my dependaents if assignment applies.

Signature _____ Date _____ Time _____

Relationship to patient _____

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PATIENT INFORMATION

Patient's name _____ (Last) _____ (First) _____ (MI) D.O.B. ____ / ____ / ____

SSN ___ - ___ - ____ Sex M F Age _____ Race _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Parent/guardian _____ D.O.B. ____ / ____ / ____ Email _____

INSURANCE INFORMATION

If patient has Medicaid, please fax/send Medicaid Referral Form (EPSDT Screening).

Person responsible for bill (guarantor) _____ Primary Group # _____

Primary policy insurance company _____ Primary Policy # _____

Cardholder's name _____ Cardholder's date of birth _____

Cardholder's address (if different from above) _____

Secondary policy insurance company _____

Secondary Group # _____ Secondary Policy # _____

Cardholder's name _____ Cardholder's date of birth _____

Cardholder's address (if different from above) _____

DIAGNOSIS

Reason for referral/other health problems _____

Date of injury _____ MV or other _____

REFERRING PHYSICIAN INFORMATION

Name _____ Physician's NPI number _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Referral number _____ Contact person/extension _____

ADDITIONAL INFORMATION

Interpreter needed? Yes / No Language/hearing/other requested _____

Allergies? Yes / No If yes, please list _____

CURRENT MEDICATIONS

Name	Dosage	Frequency	Prescribing physician

APPT _____ **PLEASE NOTIFY PARENTS OF APPOINTMENT**