Pediatric Neurology

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Dear Parent,

Thank you for choosing Huntsville Hospital Pediatric Neurology for your child's medical care.

Our website should help answer any questions about our office. We want you to know about our office services and what to expect at the time of your visit. Please complete the online New Patient Forms prior to your appointment. The completed forms must be returned to our office before your child's appointment date via mail or fax.

On the date of your child's appointment, please bring your identification cards, insurance cards, list of medications, as well as method of payment for your co-payments and/or deductibles. We ask that all patients arrive 15 minutes prior to the appointment time so your child can be seen by the doctor at the scheduled time.

If you are unable to keep your appointment or if you are going to be late, please call our office at (256) 265-1775 as soon as possible. We will be happy to reschedule a more convenient time for you.

Please note that all appointments must be confirmed at least 4 business days prior to the appointment. Failure to confirm will result in the cancellation of your child's appointment.

Sincerely,

Vanessa McVay

Vanessa McVay, CCMA
Practice Administrator
Huntsville Hospital Pediatric Neurology

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New Patient Information Sheet

Date: _____

Patient's name: _____ Sex: _____ Date of birth: _____

Name of pediatrician or family physician: _____

Chief complaint: *(What is the main problem?)*

_____

_____

Present illness:
(Describe current symptoms, when they started, what doctors have been seen and what treatments have been tried)

_____

_____

Current medications: *(Please include dosages and times when medications are taken)*

_____

_____

BIRTH HISTORY

How long was the pregnancy? _____

Were there any problems during pregnancy or labor? ☐ No ☐ Yes, explain:

_____

What medications or drugs were used during pregnancy? *(Include tobacco or alcohol)*

_____

Birth Weight: _____ Apgar scores (if known): _____ Born: ☐ Head first ☐ Feet first ☐ C-section

Describe any problems following delivery:

_____

_____

Allergies: _____

Past medical history: *(Describe ANY previous hospitalizations, surgeries, serious illnesses or infections, and include patient's age at the time of the problem)*

_____

_____

Are recommended immunizations up to date for age? ☐ Yes ☐ No ☐ Unknown

Developmental history: ☐ Normal ☐ Delayed, please explain:

_____

_____

Family history: *(Describe anyone in the family with similar problems)*

_____

_____

Mother's age: _____

List any health problems: _____

Father's age: _____

List any health problems: _____

Siblings: *(List all brothers and sisters with ages and any medical or school problems)*

_____

_____

Review of Systems Check any symptoms your child has had within the last year:

General
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Weakness
- ☐ Fatigue
- ☐ Sweats

Eyes
- ☐ Blurry vision
- ☐ Double vision
- ☐ Blindness
- ☐ Eye pain/ redness

Ears/Nose/Mouth/Throat
- ☐ Hearing impairment
- ☐ Ringing in the ears
- ☐ Ear infections
- ☐ Nosebleeds
- ☐ Bleeding gums
- ☐ Frequent sore throat
- ☐ Frequent sinus problems
- ☐ Difficulty swallowing

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Palpitations
- ☐ Heart murmur

Chest
- ☐ Cough
- ☐ Tuberculosis
- ☐ Asthma/ Wheezing
- ☐ Coughing up blood

Gastrointestinal
- ☐ Loss of appetite
- ☐ Excessive thirst
- ☐ Nausea/ vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Ulcers
- ☐ Abdominal pain

Genitourinary
- ☐ Loss of bladder control
- ☐ Increased urination
- ☐ Pain/burning urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Irregular menstrual cycle
- ☐ Age of first menstrual cycle _____

Musculoskeletal
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Neck pain
- ☐ Back problems
- ☐ Joint pain/ stiffness
- ☐ Arthritis
- ☐ Deformities

Skin/Breast
- ☐ Rashes
- ☐ Easy bruising
- ☐ Changes in hair/ nails

Endocrine
- ☐ Thyroid issues
- ☐ Goiter
- ☐ Diabetes/ blood sugar
- ☐ Heat or cold intolerance
- ☐ Poor growth
- ☐ Early puberty
- ☐ Breast development
- ☐ Delayed puberty
- ☐ Abnormal genitalia
- ☐ Pubic hair development
- ☐ Body odor
- ☐ Acne
- ☐ Abnormal facial hair (female)
- ☐ Abnormal body hair (female)

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Bleeding tendencies
- ☐ Easy bruising
- ☐ Blood transfusions
- ☐ Swollen glands

Allergic
- ☐ Eczema
- ☐ Hives
- ☐ Allergic reactions

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Hallucinations
- ☐ Drug abuse
- ☐ Alcohol abuse
- ☐ Suicidal thoughts
- ☐ Self harm (i.e. cutting)

Neurological
- ☐ Headaches
- ☐ Head injury
- ☐ Blackouts
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors
- ☐ Speech problems
- ☐ Unsteady gait
- ☐ Behavior changes
- ☐ Memory issues
- ☐ Disorientation
- ☐ Fainting
- ☐ Pain
- ☐ Stroke
- ☐ Burning
- ☐ Dizziness
- ☐ Tics

☐ **Other**, please list:

_____

_____

Please provide details of any above checked symptoms

_____

_____

Signature of person completing this form_____ Date_____

HH Pediatric Neurology

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PATIENT INFORMATION

PLEASE PRINT DATE_____

Patient's Name _____ D.O.B._____/_____/_____
LAST FIRST MI

Address _____ City _____ State _____ Zip _____

Best Phone # _____ Alternate # _____ Preferred Language _____

SS# _____-_____-_____ Sex M F Primary Care/Referring Physician _____

Mother/Guardian's Name _____ D.O.B. _____/_____/_____ SS # _____-_____-_____

Address _____Phone # ( )_____ _____

Mother/Guardian's Email_____ __ Employer_____

Father/Guardian's Name _____ D.O.B. _____/_____/_____ SS # _____-_____-_____

Address _____ _____ Phone# ( ) _____

Father/Guardian's Email _____ _____ Employer _____

Notify in case of emergency _____Relationship _____

City _____ State _____ Phone ( ) _____

If patient is a minor, list persons other than responsible party above, who have permission to bring child to office for treatment?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

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	

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 for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Pediatric Neurology to release information to insurance carriers and for insurance carriers to release information to HH Pediatric Neurology concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature of Parent/Guardian _____ Relationship to Patient _____

Date _____Time_____