



## Pediatric Endocrinology & Diabetes Clinic

Priscila Rodas, MD

Zeinab Zorkot, MD

Dear Parent,

Thank you for choosing Huntsville Hospital Pediatric Endocrinology & Diabetes Clinic 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 your child is diabetic, please bring ALL log books, glucometers, insulin and supplies to each appointment. If your child has an insulin pump or continuous glucose monitor, please bring a copy of the download for the past two weeks as we are currently unable to download these in the office.

If you are unable to keep your appointment or if you are going to be late, please call our office at (256) 265-1770 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 four business days prior to the appointment. Failure to confirm will result in the cancellation of your child's appointment.

Sincerely,

Amanda Cantrell  
Practice Administrator  
Huntsville Hospital Pediatric Endocrinology & Diabetes Clinic

920 Franklin Street  
Huntsville, AL 35801  
(256) 265-1770  
(256) 265-1761 fax



**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?)* \_\_\_\_\_

\_\_\_\_\_

Has your child had labs or other testing done for this problem? If yes, please list the location and date.

\_\_\_\_\_

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: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Apgar scores (if known): \_\_\_\_\_

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: \_\_\_\_\_ Mother's height: \_\_\_\_\_ Mother's age of first menstrual cycle: \_\_\_\_\_

List any health problems: \_\_\_\_\_

Father's age: \_\_\_\_\_ Father's height: \_\_\_\_\_ Father's age of puberty onset: \_\_\_\_\_

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
- Fainting
- Pain
- Memory issues
- Stroke
- Burning
- Disorientation
- Dizziness
- Tics

**Other**, please list:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide details of any above checked symptoms

\_\_\_\_\_  
\_\_\_\_\_

Signature of person completing this form \_\_\_\_\_ Date \_\_\_\_\_

**Patient Information**

Patient's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Sex M F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Best Phone # \_\_\_\_\_ Alternate # \_\_\_\_\_ SS# \_\_\_\_\_

Preferred Language \_\_\_\_\_ 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 \_\_\_\_\_

Patient lives with \_\_\_\_\_

**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**

Insurance Company Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's SS # or I.D. # \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

**Secondary Insurance to File**

Insurance Company Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's SS # or I.D. # \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

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 Endocrinology & Diabetes Clinic to release information to insurance carriers and for insurance carriers to release information to HH Pediatric Endocrinology & Diabetes Clinic 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 \_\_\_\_\_

**Office hours**

Monday - Thursday, 8 a.m. – 5 p.m. (Closed for lunch Noon - 1 p.m.)

Friday, 8 a.m. – 12 p.m.

**Contact Guidelines for Parents and Caregivers**

***If you have an emergency, call 911. Do not call the office with a life threatening emergency.***

If you have an urgent problem after business hours, please call the office and you will be transferred to the answering service who will contact the on-call physician. Please note at this time there is not a physician on call over the weekend except for emergencies. When our physician is out of town, there will not be a physician on call.

If you have a non-urgent problem or question, please call the office during business hours. Please allow 24 hours for the nursing staff to return your call.

Please confirm your appointment at least four business days prior to the appointment date. Failure to confirm will result in the cancellation of your child's appointment.

Failure to arrive 15 minutes prior to your child's appointment will cause the appointment to be rescheduled.

Please allow us 1-2 weeks to receive and notify you of your lab/test results, as most lab tests have to be sent out. Results are not available after business hours.

If you need forms to be completed, please drop them off at the office and allow us three business days to complete.

Contact our office during normal business hours for prescription refills. Please allow us three business days to complete. Failure to keep appointment may jeopardize medication refills. Routine medication refills are not urgent issues and will not be completed after hours.

If your prescription requires a prior authorization, please allow 7-10 business days for paperwork to be processed and the prescription to be available at your pharmacy. The exceptions are growth hormone, Lupron, insulin pump and CGM. These may take several weeks for approval. Prior authorizations cannot be addressed after hours.

If you are a diabetic patient please bring **ALL** log books, glucometers, insulin and supplies to each appointment.

If you have an insulin pump or continuous glucose monitor please bring a copy of the download for the past two weeks to your appointment.

In the case of inclement weather, please call the office to confirm we are open.