Pediatric Endocrinology & Diabetes Clinic

Linnea Larson-Williams, 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) 265-3250 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,

Vanessa Schulte

Vanessa Schulte, CCMA
Practice Administrator
Huntsville Hospital Pediatric Endocrinology & Diabetes Clinic

401 Lowell Drive, Suite 5
Huntsville, AL 35801
(256) 265-3250
(256) 265-3255 fax

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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: _____ 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 _____

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Patient Information

Patient's Name_____ D.O.B._____ Sex M F

Address _____ City _____ State ____ Zip _____

Best Phone # _____ Alternate # _____ SS# _____

Preferred Langauge _____ 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

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 _____

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Business hours Monday - Thursday 8 a.m. – 4:30 pm.
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.

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Attendance Policy

Effective 8/14/17

Because we want all of our patients to be seen and treated in a timely manner, it is important that all patients arrive on time. The following policy will be effective on August 14, 2017.

1. Patients who do not arrive 15 minutes early for their appointment may be asked to reschedule.
2. Patients who arrive early for their appointment will be seen according to their scheduled time, not their arrival time.
3. If a patient misses 3 appointments or has not been seen within one year, we will be unable to refill medications. Depending upon your insurance, a new referral may be required to be seen in our clinic again.
4. Our social worker will follow up after no-show appointments and make necessary interventions regarding any concerns.
5. If you anticipate a conflict with your scheduled appointment, please notify our office as soon as possible so that we can attempt to make adjustments as needed.

I have read and understand this policy and agree to abide by it to the best of my ability:

Patient Name: _____

Parent/Guardian Signature: _____

Witness Signature: _____

Date: _____