



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  
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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 pregnancy? 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

#### Constitution

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

#### Psychiatric

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

#### Hematological

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

#### Pulmonary

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

#### Nervous

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

#### Genitourinary

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

#### Rheumatoid/

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

#### Endocrine

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

**Other:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### ENMT

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

#### Alimentary

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

#### Integumentary

- Itchy skin
- Rashes

#### 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
<input type="checkbox"/> Severe reactions to anesthesia	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart disease before age 60	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Malignant hyperthermia	_____	<input type="checkbox"/> Sudden Infant Death Syndrome (SIDS)	_____
<input type="checkbox"/> Anemia or bleeding disorders	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Kidney disease	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> High cholesterol	_____	<input type="checkbox"/> Bowel disease	_____
<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Hereditary disease	_____

## Current Medications \_\_\_\_\_

Name	Dosage	Frequency	Prescribing physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Form completed by \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date / Time \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date / Time \_\_\_\_\_



# Tennessee Valley Pediatric Surgery

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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 \_\_\_\_\_

Employer \_\_\_\_\_ Employer address \_\_\_\_\_

Father's name \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_ 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 dependents if assignment applies.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Relationship to patient \_\_\_\_\_