New Patients

- Please arrive **15 Minutes prior** to your scheduled appointment. If you do not arrive as requested **you may need to be rescheduled.**

- Please bring **Photo ID, Insurance Cards,** and a **list of all current medications** to your appointment.

- **Parent or Legal Guardian** must bring patient to the first appointment.

- Please make sure **all paperwork** is filled out **prior to appointment**, failure to do so may result in your appointment being rescheduled.

Thank you for your cooperation.

Covenant Pediatric Neurology

PF08213

ASSIGNMENT OF BENEFITS

NAME: ____
(LAST) (FIRST) (INITIAL) (NICKNAME/GOES BY)

ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE:(____) ______________ WORK/ALTERNATE PHONE:(____) ______________

EMAIL: ______________________________ PRIMARY LANGUAGE SPOKEN ______________

BIRTHDATE: ____________ AGE: ________ MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D SEX: ☐ F ☐ M

EMPLOYER: ______________________________ SS#: ______________________

SPOUSE'S FULL NAME: ______________________________ SS#: ______________________

SPOUSE'S EMPLOYER: ______________________________ WORK PHONE:(____) ______________

IN CASE OF EMERGENCY: (Relative outside of your household)

1) ______________________ RELATIONSHIP ____________ PHONE:(____) ______________

2) ______________________ RELATIONSHIP ____________ PHONE:(____) ______________

INSURANCE

PRIMARY: ______________________ SUBSCRIBER'S NAME: ______________________

EMPLOYER: ______________________ SS#: ______________ DOB: ______________

SECONDARY: ______________________ SUBSCRIBER'S NAME: ______________________

EMPLOYER: ______________________ SS#: ______________ DOB: ______________

FOR MINOR CHILDREN UNDER 18 YEARS OF AGE:

MOTHER'S FULL LEGAL NAME: ______________________________ SS#: ______________

MOTHER'S ADDRESS: ____

FATHER'S FULL LEGAL NAME: ______________________________ SS#: ______________

FATHER'S ADDRESS: ____

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I authorize the physician and/or surgeon to release any information from his or her records regarding my care to the insurance company where coverage is established. I hereby authorize payment to be made directly to the provider of medical service for expenses otherwise payable to me as determined by the insurance company.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

PATIENT: ____ DATE: ______________
(PARENT IF MINOR)

(R 10/10)

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

PF08203 (R 12/04)

ACKNOWLEDGMENT/ RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT I.D.

I acknowledge, by signing below, that I have received a copy of the Covenant HealthCare **Notice of Privacy Practices**.

____
Name

____
Signature

Date:____/____/____

Covenant HealthCare Staff Use Only

Acknowledgment Received:______/______/______

Reason Acknowledgment **was not** Received:

☐ I have previously received the Notice of Privacy Practices.

☐ Other, explain:

____

____

____

Covenant HealthCare Staff ______________________________
(Signature)

COVENANT HealthCare

HEALTH HISTORY/CHILD
BIRTH THRU 11 YEARS OF AGE
(PHYSICIAN OFFICE)

SAFETY

	Yes	No
Does anyone smoke at home?	☐	☐
Do you have a smoke detector?	☐	☐
Do you have any guns at home?	☐	☐
Is hot water heater down to 120°F?	☐	☐
Does your child wear a helmet when riding a bike, skating, etc?	☐	☐
Is the Poison Control phone # posted?	☐	☐
Does your child always use car seat or seat belt?	☐	☐

DENTAL

	Yes	No
Do you have well water in your home?	☐	☐
Please answer if child is 2 years or older:		
Does your child brush his/her teeth daily?	☐	☐
Does your child see a dentist regularly?	☐	☐

SCHOOL

Please answer if child has started school:	Yes	No
Does your child attend daycare/preschool?	☐	☐
Has your child failed any grades?	☐	☐
Has your child had any learning problems?	☐	☐
Has your child been absent from school more than 10 days a year?	☐	☐

HOSPITALIZATIONS

Date ________ Reason ____________________

________ ____________________

PREVIOUS SURGERIES

Date ________ Type ____________________

________ ____________________

ALLERGIES

Please check any allergies you have and the reaction:

	Reaction
☐ Erythromycin	________
☐ Bactrim/Septra	________
☐ Aspirin	________
☐ Amoxicillin	________
☐ Ceclor	________
☐ Bee Sting	________
☐ Food	________
☐ Other (List)	________
☐ No Known Allergies	

NUTRITION

	Yes	No
Does your child have any eating problems?	☐	☐
Please answer if child is 1 year or older:		
Do you limit sweets/junk food?	☐	☐
Does your child skip meals?	☐	☐
Does your child eat paint chips or chew on window sills?	☐	☐
Is your child in WIC program?	☐	☐

BEHAVIOR

Please check behavioral problems if child is 1 year or older:

☐ Temper Tantrums ☐ Steals ☐ Lies
☐ Whines ☐ Cries Easily ☐ Hyperactive
☐ Hits/Bites ☐ Short Attention Span ☐ Shyness
☐ Disobedient ☐ Sleep Problems
☐ Suicidal Thought/Threat ☐ Coping Skills
☐ Depression ☐ Anxiety

Other (List): ____________________

____

MEDICINES

List all medications you are taking, including prescriptions and over-the-counter medicines.

Medication & Dosage	Reason
________	________
________	________
________	________
________	________

IMMUNIZATIONS / TB TESTS

Please check any immunizations you have had and the approximate year.

	Date	Date	Date	Date	Date
☐ DPT	____	____	____	____	____
☐ Td	____	____	____	____	____
☐ Polio	____	____	____	____	____
☐ MMR	____	____	____	____	____
☐ Hib	____	____	____	____	____
☐ Hep B	____	____	____	____	____
☐ Varicella	____	____	____	____	____
☐ TB Skin Test	____	____	____	____	____

PAST ILLNESSES - Please answer for any age child

	Yes	No		Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Frequent Sore Throats/Colds	☐	☐	Pneumonia	☐	☐	Kidney Problems	☐	☐
Tonsilitis	☐	☐	Hearing Loss	☐	☐	Blood Disorder	☐	☐	Constipation	☐	☐
Chicken Pox	☐	☐	Allergies	☐	☐	Frequent Headaches	☐	☐	Bladder Infection	☐	☐
High Cholesterol	☐	☐	Sleep Apnea	☐	☐	Skin Problems	☐	☐	Frequent Ear Infections	☐	☐
Bedwetting	☐	☐	Heart Murmur	☐	☐	Seizures	☐	☐			

COVENANT HealthCare

HEALTH HISTORY/CHILD BIRTH THRU 11 YEARS OF AGE (PHYSICIAN OFFICE)

Date ____________________

Name ________________________________ Age ________ Gender ________ Date of Birth ________

FAMILY HISTORY

Mother's name ________________________________ Age ________ Living at home? ☐ Yes ☐ No

Mother's health ________________________________ Occupation ________________

Father's name ________________________________ Age ________ Living at home? ☐ Yes ☐ No

Father's health ________________________________ Occupation ________________

Brothers & Sisters Names	Birthdates

Has any blood relative had any of the following:

	Yes	Relationship	No		Yes	Relationship	No		Yes	Relationship	No
Asthma	☐		☐	Allergies	☐		☐	Mental Retardation	☐		☐
Tuberculosis	☐		☐	Depression	☐		☐	Kidney Problems	☐		☐
Diabetes	☐		☐	Eczema	☐		☐	High Cholesterol	☐		☐
Stroke	☐		☐	Seizures	☐		☐	High Blood Pressure	☐		☐
Heart Disease	☐		☐	Hearing Loss	☐		☐	Blood Disease	☐		☐
SIDS	☐		☐	Alcoholism	☐		☐	Drug Addiction	☐		☐
Cancer	☐		☐								

Please circle any problems during pregnancy:

Bleeding   Swelling   High Blood Pressure

Kidney Infection   Diabetes   Vaginal Infection

Birth Weight ________ lbs ________ oz

Was birth ________ On Time ________ Early?

Was delivery ________ Vaginal ________ C-Section?

Did the mother have any problems during or after labor and delivery? ☐ Yes ☐ No

Please circle any problems your baby had in the hospital after delivery.

Yellow jaundice   Turned Blue   Seizures

Vomiting   Breathing Trouble   Infection   Constipation

	Yes	No
Was this pregnancy planned?	☐	☐
During pregnancy did the mother:		
- Smoke?	☐	☐
- Drink Alcohol?	☐	☐
- Take any medication?	☐	☐

Please list: ________________________________

Did the mother do drugs during pregnancy? ☐ ☐

Please list: ________________________________

DEVELOPMENT

Please complete this section if your child is under 2 years.
Please list the age in months when your child did each of the following:

Transferred objects from one hand to the other: ________ Smiled: ________ Turned Head to Voice: ________

Fed Self: ________ Sat Alone: ________ Crawled: ________ Walked Alone: ________

Said 2 Words: ________ Said 10 Words: ________

COVENANT PEDIATRIC NEUROLOGY
BIRTH HISTORY

Vaginal Delivery______________ C-Section___________________

Gestational Age_______________

Complicatiions____

____

DEVELOPMENTAL HISTORY

Age when first sat up_____________

Age when first able to walk____________

Age when first able to stand___________

Grade________

Special ED ? ________