COVENANT NEUROSURGERY

CHILD HEALTH HISTORY

7 year of age through 14 years of age

Date: ____________

Patient Name:______________________________ Date of birth:____________ Age:______ Gender:______

FAMILY HISTORY

Mother's Name:______________________________ Age:________ Occupation:____________________

Mother's Health:______________________________ Does patient live with mother?:________

Father's Name:______________________________ Age:________ Occupation:____________________

Father's Health:______________________________ Does patient live with father?:________

Brothers and Sisters:

Name	Age	Health Problems	Immunizations Up To Date

Please check if any BLOOD RELATIVE has had any of the following and list their relationship to the patient:

Alcoholism	________	Allergies	________	Asthma	________
Blood Disease	________	Cancer	________	Depression	________
Diabetes	________	Drug Addiction	________	Eczema	________
Hearing Loss	________	Heart Disease	________	High Blood Pressure	________
High Cholesterol	________	Kidney Disease	________	Mental Retardation	________
Seizures	________	SIDS	________	Stroke	________
Tuberculosis	________				

Please check if the PATIENT has had any of the following

O Allergies	O Depression	O Hepatitis	O Rheumatic Fever
O Asthma	O Eczema	O High Cholesterol	O Seizures
O Bladder infection	O Hearing Loss	O Kidney Problems	O Tuberculosis
O Chicken pox	O Heart Murmur	O Pneumonia	Other:____________________

MEDICATIONS

List all medications child is taking, including over-the counter medications

____

____

ALLERGIES

Please list any allergies your child has and the reaction.

____

____

HOSPITALIZATIONS/SURGERIES

Please list any hospitalizations or surgeries patient has had

____

____

____

____

IMMUNIZATIONS/TB TESTS UP TO DATE?

	Yes	No
DPT	____	____
TD	____	____
Polio	____	____
MMR	____	____
HIB	____	____
Hep B	____	____
TB Skin Test	____	____

SOCIAL HISTORY

(Answer questions appropriate to child's age.)

	Yes	No
Do you exercise at least 3 times a week?	____	____
Do you smoke cigarettes?	____	____
if yes how much____________________		
Do you chew tobacco?	____	____
if yes, how often and what kind?__________		
Do you use drugs?	____	____
if yes, how often and what kind?__________		
Have you ever taken steroids?	____	____
Do you drink alcohol?	____	____
if yes, how much and how often?__________		
Are you sexually active?	____	____

SAFETY

	Yes	No
Do you always wear a seatbelt?	____	____
Do you wear a helmet when riding A bike, motorcycle or skating	____	____

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

CONSENT/PATIENT INFORMATION

PF02996 (2/11)

PATIENT I.D.

Patient Full Legal Name: ____________________ Photo ID: y/n ________

Date of Birth: ________ Soc Sec #: ____________ Patient Sex: ______ Male ______ Female

Address: ____________________ Marital Status: S / M / D / W

City, State, Zip: ____________________ Ethnicity: ____________________

Telephone: ____________________ Preferred Language: ____________________

Cell Phone#:(________) ____________________ Race: White / Black / Hispanic / Asian / Other

Email Address: ____

Contact Person Other than Home: ____________________ Telephone #: (______) ________ - ________

Patient Employer: ____________________ Employer Telephone: ____________________

Employer Address: ____________________ Date of Retirement: ____________________

Student:Full Time: ________ Part Time: ________ Parent/Guardian: ____________________

Family Doctor: ____________________ ReferringDoctor: ____________________

Pharmacy ____________________ Location: ____________________

BILL TO:Self___Parent/Guardian____Work comp____Auto____Insured Name & Date of Birth ____________________

Primary Insurance: ____________________ Secondary Insurance: ____________________

Spouse Name: ____________________ Spouse Employer: ____________________

Spouse Date of Birth: ____________________ Employer Address: ____________________

Spouse Soc. Sec. #: ________ - ______ - ________ Date of Retirement: ____________________

AUTHORIZATION FOR MEDICAL INSURANCE BENEFITS

1) I assign payment to be made on my behalf to Covenant Healthcare.
2) I also authorize Covenant Healthcare to furnish information necessary for claims processing to any insurance carrier concerning my illness and treatments.
3) A universal claim form will be completed to help expedite insurance carrier payment.
4) I understand that all professional services will be charged to the patient for insurance other than our participating carriers.
5) Payment of the account is the patientis direct responsibility and I am responsible for any non-paid services.
6) Payment for services are due when rendered unless other arrangements have been made in advance with our billing staff.

________________ Date

________________________________ Patient Signature/Guardian

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)

Authorization for Release of Information

This may include your spouse, children, siblings, caregiver, etc

Date:___________________________________

I, _____________________________________, give Covenant Neurosurgery permission to release and/or discuss my medical information with the following people:

Name:____

Relationship:__________________________________Phone:_________________

Name:____

Relationship:__________________________________Phone:_________________

Name:____

Relationship:__________________________________Phone:_________________

I, ________________________________, give consent to the office listed above to identify themselves and leave messages on the answering machines/voice mails attached to the phone numbers I have listed as my contact numbers. I understand that the messages may include information on dates of future appointments and/or test results.

______________________________________ _______________ _______________

Patient Signature * Date of Birth Date

______________________________________ _______________

Witness Date