COVENANT NEUROSURGERY
CHILD HEALTH HISTORY
Birth through 6 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 Problems	☐_________	Mental Retardation	☐_________
Seizures	☐_________	SIDS	☐_________	Stroke	☐_________
Tuberculosis	☐_________				

Please check if the PATIENT has had any of the following:

Allergies	☐	Chicken Pox	☐	Hearing Loss	☐	Seizures	☐
Asthma	☐	Constipation	☐	Heart Murmur	☐	Skin Problems	☐
Bed Wetting	☐	Frequent Ear Infections	☐	High Cholesterol	☐	Sleep Apnea	☐
Bladder Infection	☐	Frequent Headaches	☐	Kidney Problems	☐	Tonsillitis	☐
Bladder Disorder	☐	Frequent Sore Throats/Cough		Pneumonia	☐	Other: _________	

Please Circle any problems during pregnancy:

Bleeding   Diabetes   High Blood Pressure   Kidney Infection   Swelling   Vaginal Infection

Was the pregnancy planned? __________
Birth Weight: __________
Was Birth: _____ on time _____ early
Was Delivery: _____ Vaginal _____ C-Section
Did mother have any problems during or after labor and delivery? _____

During pregnancy did mother smoke? __________
If yes, how much per day? __________
Did mother use drugs during pregnancy?
If yes, what kind? __________
Were medications taken during pregnancy? ____________
If yes, please list: ______________________________

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

Breathing Trouble   Constipation   Infection   Seizures   Turned Blue   Vomiting   Yellow Jaundice

Development

Please complete this section if your child is less than 2 years old. Please list age in months as to when your child id each of the following:

Transferred objects from one hand to another _____ Smiled _____ Turned head to voice _____ Feed Self _____

Sit alone _____ Crawled _____ Walked alone _____ Say 2 words _____ Say 10 words _____

MEDICATIONS

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

Medication **Dosage**

____

____

____

____

ALLERGIES

Please list any allergies your child has and the reaction.

____

____

____

____

HOSPITALIZATIONS/SURGERIES

Please list any hospitalizations or surgeries patient had

____

____

____

____

____

IMMUNIZATIONS/TB TESTS UP TO DATE?

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

SAFETY

	Yes	No
Does any one Smoke at home?	___	___
Do you have a smoke detector?	___	___
Do you have any guns in the home?	___	___
Is hot water down to 120°F?	___	___
Does your child wear a helmet when riding a bike, skating, etc…	___	___
Is the Poison Control Number Posted?	___	___
Does your child always use a car seat Or seat belt?	___	___

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 patientís 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
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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