PEDIATRIC REGISTRATION FORM

**********Patient Information**********

Pt. Last Name	First	Middle Init
Date of Birth	Age	Gender
Address	City	St / Zip
Pharmacy Name & Location	Phone Number	

**********Parent / Guardian Information**********

FATHER (Guardian) Last Name	First	Middle Init
SSN	Date of Birth	
Home phone	Cell phone	Email / Work phone
Employer	Emp Address	City / St / Zip / Emp Phone
MOTHER (Guardian) Last Name	First	Middle Init
SSN	Date of Birth	
Employer	Emp Address	City / St / Zip / Emp Phone
Home phone	Cell phone	Email / Work phone

Contact Preference for appt reminders, medical information and financial info (Please rank by preference – 1 – 5):
_____ Cell Phone _____ Email _____ Text _____ Home Phone _____ Work Phone

**********Contact in Case of Emergency**********

Contact Name	Relationship
Home Phone	Cell Phone / Work Phone

**********Referring Physician**********

Referred by:			
If referred by Doctor: Address	City	St	Zip
Phone	Fax		

**********Pediatrician**********

Primary Care Physician			
Address	City	St	Zip
Phone	Fax		

Initial _____ Date _____

**********Financial Responsibility**********

Person Financially Responsible for Balance Not Covered by Insurance	Relation (Patient/Parent/Guardian)
Name on Credit Card	

Visa Card # / Master Card # / Discover Card #	Exp Date	CVCODE

I hereby authorize the doctor to charge my listed credit card account any unpaid balance

Signature	Date

**********Primary Insurance Information**********

Insurance Co.	Subscriber	Date of Birth
ID	Group	

Mailing Address	City	St	Zip
Phone			

**********Secondary Insurance Information**********

Insurance Co.	Subscriber	Date of Birth
ID	Group	

Mailing Address	City	St	Zip
Phone			

**********W/C or Accident Insurance Specific Information**********

W/C or Accident Insurance Name	Adjuster's Name		
Address	City	St	Zip
Phone	Fax	Claim #	
Do you have an attorney handling your claim?	Name		
Address	City	St	Zip
Phone	Fax	Claim #	

I authorize the Release of any Medical Information to process my claim and request Payment of Benefits to the Physician. I understand that responsibility for payment for neurosurgical services provided by this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance.

Relationship to patient	**Date**
Signature	

Initial _____ Date _____

**********Health Information**********

Reason for Visit	
Approximate date of condition onset	
Have any tests been done?	What was done?
Has any treatment been tried?	What was done?

**********Current and Complete Medication List **********
(including over-the-counter drugs such as aspirin, vitamins, herbal supplements)

Medication Name	Dose	How Often

*Drug, Food or Substance Allergies (Including any medications or Latex)** **[IF NO ALLERGIES _____]**

Allergy To:	Reaction Type:	Allergy To:	Reaction Type:

**********Pregnancy History**********

Full Term (Y / N)	Premature (Y / N)	How many weeks?	Birth weight?
Any Problems with your pregnancy?	Y / N	If yes, please describe:	
DELIVERY:	Vaginal	Cesarean	If Cesarean, why?
Stayed in NICU?	Y / N	Reason:	
Birth defects?	Y / N	Please describe:	
Does your child have any birthmarks?	Y / N	Please describe:	

**********Past Medical History (Please check if your child has ever had any of the following)**********

	Anemia		Blood clots		Hepatitis C		Kidney failure		Seizure disorder
	Asthma		CVA/TIA (Stroke)		HIV/AIDS		Liver disease		Thyroid disease
	Atrial fibrillation		Diabetes		Hypertension		Renal disease		

Initial _____ Date _____

**********Past Surgical Procedures and Hospitalizations**********

Reason	Date	Which Hospital
Anesthesia reaction?		
VP shunt revision?		

Family History (Please check if any of the following conditions exist within your family (NOT your child)

	DIAGNOSIS:	WHICH FAMILY MEMBER:	AGE ONSET or DEATH:		DIAGNOSIS:	WHICH FAMILY MEMBER:	AGE ONSET or DEATH:
	Blood disease				High blood pressure		
	CAD				Kidney /bladder problems		
	CVA (Stroke)				Sickle cell anemia		
	Diabetes				Anesthesia problems		
	Cancer (type)						

(DO NOT USE FOR ANY CHILD UNDER 3 – ANSWER ONLY FOR CHILDREN 4 AND OLDER)

*********Review of Systems (is your child currently having problems with any of the following)********

CONSTITUTIONAL:		Chills		Fatigue		Fever		Weight change (+ or -)
EYES:		Double Vision		Eye pain		Floaters		Visual loss
EARS/NOSE/THROAT:		Hearing loss/ringing		Nose bleeds		Voice change		Trouble swallowing
RESPIRATORY:		Cough		Short of breath		Frequent infections		Wheezing
CARDIOVASCULAR:		Chest pain		Short of breath		Swelling of legs		Palpitations
GASTROINTESTINAL:		Stomach pain		Fecal incontinence		Rectal bleeding		Vomiting
GENITOURINARY:		Cloudy urine		Decreased stream		Foul urine odor		Frequent urination
		Blood in urine		Kidney stones		Urgency		Urinary incontinence
ENDOCRINE:		Excessive urination		Weight gain		Weight loss		
NEUROLOGICAL:		Weakness		Headache		Memory impairment		Seizures
PSYCHIATRIC:		Sociability		Frequent upset		Difficulty concentrating		Depression
SKIN:		Frequent skin infections		Nail changes		Rash		Change in mole
MUSCULOSKELETAL:		Back pain		Bone/joint symptoms		Muscle soreness		Neck stiffness
HEMATOLOGIC:		Bleeding Problems		Bruise easily		Enlarged glands		Blood clots
IMMUNOLOGICAL:		Asthma		Environmental allergies		Food allergies		

Initial _____ Date _____

**********Social History**********

PRIMARY LANGUAGE SPOKEN:		**LANGUAGE SPOKEN AT HOME:**	
COUNTRY OF BIRTH:			

HEIGHT:		**WEIGHT:**				**AGE:**
HAND DOMINANCE:		Right		Left		Ambidextrous

RESIDENCE INCLUDES WHO:	
WHO COMPRISES YOUR SUPPORT NETWORK:	

(PLEASE ANSWER FOR ALL CHILDREN:)

PASSIVE SMOKE EXPOSURE:	Yes / No

(PLEASE ANSWER FOR ALL CHILDREN 13 AND OVER:)

USES TOBACCO:	Current / Former / Never	Type:	How much daily?	Years used:
Have you ever tried to quit?	Year quit?	Longest time tobacco free:	Relapse reason?	

CHANGES IN SLEEP PATTERNS?	If so, what changes?		
ACTIVITY LEVEL:	Moderate	Sedentary	Vigorous

PERSONAL SAFETY:	Has your child fallen and been injured in the last 12 months?	Number of falls:

Initial _____ Date _____

CENTER OF BRAIN AND SPINE SURGERY
JERRY BAUER, M.D., F.A.C.S.
JOHN RUGE, M.D., F.A.C.S.
MARTIN D. HERMAN, M.D., PH.D., F.A.C.S.
GEORGE K. BOVIS, M.D.
SHAUN O'LEARY., MD

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PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

We understand that the privacy of your personal information is important to you. As your physicians, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies, please do not hesitate to ask our privacy officer Kris R, who can be reached at (847) 698-1088.

Information We Collect About You

We collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities, and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian. The Center of Brain and Spin Surgery does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

Safeguarding Your Personal and Health Information

We are required by law to 1) make sure that medical information that identifies you is kept private 2) provide you with our privacy policy 3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide service to you. The Center of Brain and Spine Surgery maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with the Center of Brain and Spine Surgery.

Changes To Our Privacy Policy

All new patients will receive a copy of our privacy. The Center of Brain and Spine occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be posted in our office and copies available at the front desk prior to the effective date of changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Acknowledged _____ **Date** _____

Initial _____ Date _____