Helen DeVos
children's hospital

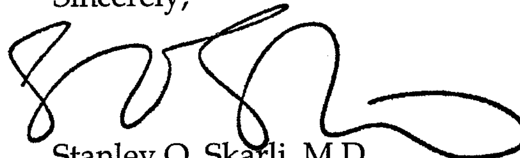
Pediatric Neurosurgery Clinic
412 Plymouth Avenue NE Grand Rapids MI 49505-6028
devoschildrens.org

Dear Patient and Parent/Guardian,

Enclosed is a ***Medical History Form*** that we are asking you to complete and bring back to our office on the day of your appointment. We realize that the form is lengthy, but we ask that you ***answer every single question*** for two very important reasons. First, and most importantly, the information you provide will help us to render better neurosurgical care for you. Secondly, the information you provide helps us to assist you in securing any insurance benefit you may be entitled to receive. You will also find enclosed a ***Patient Information Form*** that you should complete and some directions to our facility.

Thank you in advance for taking the time necessary to complete this paperwork. We look forward to the privilege of participating in your neurosurgical care.

Sincerely,



Stanley O. Skarli, M.D.
Helen DeVos Children's Hospital
Pediatric Neurosurgery Clinic

SOS/psi

Helen DeVos children's hospital

Pediatric Neurosurgery Clinic
Lawrence T. Foody, M.D., Ph.D.
Stanley O. Skarli, M.D.

____
Patient's Last Name First Name Middle Name

____
Address City State Zip

____
Date of Birth Age Sex SS#

____
Home Telephone# Father/Guardian's Work # Mother/Guardian's Work #

____
Cell Phone #'s Email address

Father/Guardian ____

Date of Birth __________________ SS# ____________________________

Address (if different than patient's): ___________________________________

____

Employer ____

Address ____

Telephone # _____________________________

Mother/Guardian ____

Date of Birth __________________ SS# ____________________________

Address (if different than patient's): ___________________________________

____

Employer ____

Address ____

Telephone # ______________________________

Pediatrician or Family Physician ______________________________

Address ____

Telephone # ______________________________

Who referred this patient to our Pediatric Neurosurgical Clinic? ______________

____

Is the visit the result of an accident? YES ☐ NO ☐ Date ______________

Type ____

Briefly describe accident ________________________________

____

____

Reason for today's visit ________________________________

____

____

HEALTH INSURANCE: ***(Please present your insurance card(s) to our receptionist.)***

Primary Insurance Company:

____

ID#: ______________________________

Group #: ____________________

Name of Insured: ______________________________

Secondary Insurance Company:

____

ID#: ______________________________

Group #:____________________

Name of Insured: ____

I hereby authorize the release of any medical information necessary to process my insurance claims to the above listed insurance companies. This may include information related to HIV, alcohol or substance abuse, mental health or other medical conditions.

Signature: ____

Date: ______________________

I hereby authorize payment of any medical benefits to go directly to the provider of service. I understand that I am responsible for any amounts not covered by my insurance plan.

Signature: ____

Date: ____________________________

HDVCH PEDIATRIC NEUROSURGERY MEDICAL HEALTH HISTORY FORM					
GENERAL INFORMATION					
Name:					Phone (Home):
Address:	City:	State:	Zip code:		Phone (Work):
Date of birth:	Age:	Sex: M F	Marital Status: S M W D		Phone (Cell):
Height: ______' _______"	Weight: ______ lbs.	Right-handed ____ or Left-handed _____			
Family Physician Name:					Phone Number:
Who referred you to our office?:					Phone Number:
					Social Security Number:
Insurance (Company name and ID numbers):					

NEUROSURGICAL HISTORY
What problem brought you to our office today?
What were you doing when this problem occurred?
How long have you experienced this problem (in terms of days, months or years)?
Is this problem associated with: Numbness Tingling Weakness (Please circle all that apply and indicate what part of your body is affected):
Have you had this problem in the past? Y _____ N _____ If so, when? ___________________

Today's Date: ____

Describe the location of any pain you are having:

Describe the type of pain you are experiencing:

Sharp____ Burning _____ Pressure _____

Dull____ Shooting _____ Other ______________________

What worsens the pain?:

Standing ____ Climbing stairs ____ Lifting _____ Coughing or sneezing _____

Sitting ____ Walking ____ Bending ____ Straining ____

Twisting _____

What relieves the pain or discomfort?:

Have you experienced any of the following?:

Impaired vision Y____ N____ Double vision Y ____ N ____

Impaired hearing Y____ N____ Loss of smell Y ____ N ____

Numbness Y____ N____ Tingling Y____ N____

Facial nerve injury or paralysis? Y ____ N ____ Blackout spells or seizures? Y _____ N _____

Concussion or severe head injury? Y _____ N _____

Previous diagnostic tests performed (give dates and medical facility, if known):

Spine X-rays: CT Scan:

Skull X-rays: MRI:

Myelogram:
(X-ray dye put in spine)

EMG:
(needle test in arms or legs)

Angiogram:
(X-ray dye put in blood vessels)

Treatments attempted:

Decreased activity_____ Heat _____ Chiropractor _____

Bedrest_____ Ice _____ Physical therapy _____

Cortisone/epidural injections _____ Medication _____ Traction _____

PAST / FAMILY / SOCIAL HISTORY

Are you allergic to any medication(s)?: Y _____ N _____

(If yes, please list medication name(s):

Any other allergies?: Y _____ N _____

If yes, please list: (include ***MEDICATIONS, ANESTHESIA, DYE, foods, soaps, latex, other)***

Please list all prior hospitalizations or surgeries:	
Date:	Reason for Hospilization/Surgery:

Please list all other health-related problems, diseases, prior illnesses, or injuries:	
Date:	Health-related problem, disease, illness, or injury:

Childhood Illnesses:

Medications: (Please list all medications you are currently taking, both prescription and non-prescription)

Name of Medication	Dosage	Frequency	Reason for Medication

Which pharmacy do you use most frequently: Phone:

Do you use alcohol? N___ Y___ (If "Y" please list type and amount)

Do you smoke? N ___ Y ___ (If "Y" please list number of packs per day): _________ packs

Do you now, or have you ever, abused alcohol or drugs? N___ Y___ (If "Y" please explain briefly)

Are you on a special diet? N___ Y____(if "Y", please explain)

FAMILY HISTORY: Please describe the health history of your immediate family

Mother: Living: Y ___ N ___ (If deceased, please indicate the cause of death)

Health Problems: N___Y___(If "Y", please describe)

Father: Living: Y ___ N ___ (If deceased, please indicate the cause of death)

Health Problems: N___Y___(If "Y", please describe)

Brother(s): How many? ___ All living? Y ___ N ___ (If deceased, please indicate cause of death)

Health Problems: N___Y___(If "Y", please describe)

Sister(s): How many? ___ All living? Y ___ N ___ (If deceased, please indicate cause of death)

Health Problems: N___Y___(If "Y", please describe)

Children: How many? ___ All living? Y ___ N ___ (If deceased, please indicate cause of death)

Health Problems: N___Y___(If "Y", please describe)

Do any other family members have significant health problems? If so, please describe.

Have you experienced any of the following? If 'Y", please indicate the approximate date and explain.			
Y__ N__	Unexplained Fevers	Y__ N__	Stomach Trouble
Y__ N__	Eye Problems	Y__ N__	Liver Problems
Y__ N__	Glasses?	Y__ N__	Ulcer
Y__ N__	Double/blurred vision	Y__ N__	Hepatitis
Y__ N__	Hearing Problems	Y__ N__	Blood in stools
Y__ N__	Chronic Sinusitis	Y__ N__	Nausea / Vomiting
Y__ N__	Hoarseness	Y__ N__	Diarrhea
Y__ N__	Chronic Bronchitis	Y__ N__	Constipation
Y__ N__	Shortness of Breath	Y__ N__	Kidney Trouble
Y__ N__	Difficulty Breathing	Y__ N__	Incontinence
Y__ N__	At night?	Y__ N__	Decreased urination
Y__ N__	With stairs?	Y__ N__	Kidney Stones
Y__ N__	Chronic Cough	Y__ N__	HIV / AIDS
Y__ N__	Bloody Sputum	Y__ N__	Other sexually transmitted disease
Y__ N__	Tuberculosis (TB)		Female Patients:
Y__ N__	Asthma		# of Pregnancies: ________
Y__ N__	Emphysema		Date of LMP: __________
Y__ N__	Rheumatic Fever	Y__ N__	Arthritis
Y__ N__	High Blood Pressure	Y__ N__	Leg Cramps
Y__ N__	Seizures / Epilepsy	Y__ N__	Swelling
Y__ N__	Chest Pain / Pressure	Y__ N__	Anemia
Y__ N__	Heart Murmur	Y__ N__	Leukemia
Y__ N__	Heart Palpitations	Y__ N__	Bleeding Problems
Y__ N__	Mental Illness	Y__ N__	Sickle Cell Anemia
Y__ N__	Depression	Y__ N__	Blood Clots
Y__ N__	Anxiety	Y__ N__	Phlebitis
Y__ N__	Other:	Y__ N__	Varicose Veins
Y__ N__	Numbness	Y__ N__	Pain when walking
Y__ N__	Headaches	Y__ N__	Thyroid Disease
Y__ N__	Migraine Headaches	Y__ N__	Diabetes
Y__ N__	Stroke	Y__ N__	Cancer (List area):
Y__ N__	Childhood Illnesses		Other:

I hereby certify that the above information is correct to the best of my knowledge. I will not hold my physician or any of his staff responsible for any errors or omissions I have made in completing this form.	
Patient's signature:	**Date:**
Reviewed and / or updated by:	
Physician's signature:	**Date:**
Physician's signature:	**Date:**
Physician's signature:	**Date:**
Physician's signature:	**Date:**
Physician's signature:	**Date:**
Physician's signature:	**Date:**

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PRESCRIPTION POLICY OF HELEN DEVOS CHILDREN'S HOSPITAL PEDIATRIC NEUROSURGERY CLINIC

Prescription pain medications have the ability to become addictive. Because we are concerned about our patient's health, we have developed the following policy concerning prescription medications:

1. Medication is not ordered for patients seeking second surgical opinions.
2. Medication is not ordered for patients when surgery has not been indicated.
3. Medication is ordered for pre and postoperative patients and the dosage will be tapered under the physician's discretion.
4. Once pain medications are prescribed by our physicians, you agree that our office will *SOLELY* manager those pain medications; in other words, you agree *NOT* to take pain medications prescribed by other physicians. However:

➢ After you have been referred to another specialty or have been released back to your primary care physician, our office will no longer prescribe pain medications.

5. Prescription pain medications will not be ordered in dosages that exceed the recommended levels listed in the Physician's Desk Reference.
6. You agree *NOT* to drive motor vehicles or operate heavy machinery while taking narcotic pain medication. You agree *NOT* to use alcohol or recreational drugs while taking any prescription pain medications.
7. Prescriptions:

    ➢ Will only be renewed from 9 am to 3 pm Monday through Friday.
    ➢ Twenty-four hours must be allowed for prescriptions to be called in.
    ➢ No prescriptions are issued for non-hospitalized patients during evenings, weekends or holidays.

I have thoroughly red and understand the above policy and agree to its contents.

______________________________ ______________
Patient or Authorized Representative's Signature Date

PRIORITY HEALTH
Cost Management Department
PO Box 232
Grand Rapids, MI 49501-0232

Dear patient: Priority Health has requested this questionnaire be presented to you for completion. The answers will help expedite the benefit consideration of your claim. Please complete all information that applies, and use reverse side if more space is necessary.

Great Lakes Neurosurgical Associates, P.C.
414 Plymouth N.E.
Grand Rapids, MI 49505

Date: ______________

Patient Name: ______________________________

Subscriber Name: ______________________________

Member/Participant Number: ______________________________

1. Briefly describe the condition or diagnosis:
   DX Code: ______________________________
   ____

2. Are the medical services received a result of an injury?
   Yes ☐ No ☐
   If "yes", please complete the following:
   Date injury occurred: ______________
   Where the injury took place:
   ____
   Names and addresses of all parties involved:
   ____
   ____
   ____
   ____
   ____
   ____
   Please provide full description of how injury occurred:
   ____
   ____
   ____

3. Is this condition, diagnosis or injury related to past or present employment?
   Yes ☐ No ☐
   If "yes", please complete the following:
   Was injury reported to employer?
   Yes ☐ No ☐
   Has Workers' Compensation claim been filed?
   Yes ☐ No ☐
   Employer Name: ______________________________
   Address: ______________________________
   ____
   Length of employment: ______________
   Please describe in detail tasks performed as a regular part of that job:
   ____
   ____
   ____

4. Is this condition, diagnosis or injury covered by any other insurance?
   Yes ☐ No ☐
   If "yes", please complete the following:
   Type of insurance:
   - ☐ Homeowners
   - ☐ Workers' Compensation
   - ☐ Auto
     If the condition, diagnosis or injury resulted from any involvement with an automobile, please send a copy of the personal injury protection section of the policy that was in effect at that time to Priority Health, PO Box 232, Grand Rapids, MI 49501-0232.
   - ☐ Business Owners
   - ☐ Other: ______________

   Policy Number: ______________
   Claim Number: ______________
   Policyholder Name: ______________
   Address: ______________
   ____

   Insurance Company: ______________
   Address: ______________
   ____

   Agent Name: ______________
   Address: ______________
   ____
   Telephone Number: ______________

5. Has an attorney has been consulted regarding this condition, diagnosis or injury?
   Yes ☐ No ☐
   If "yes", please complete the following:
   Attorney Name: ______________
   Address: ______________
   ____
   Telephone Number: ______________

6. Patient/Subscriber Signature:
   ____
   Date: ______________