Department of Orthopaedic Surgery

CHILDREN'S HOSPITAL

Dear Parent,

We would like to welcome you and your child to Children's Hospital Ambulatory Care Center. It is our objective to provide quality medical care in a courteous and efficient manner to any child in need of medical attention.

Regarding Your Appointment

Please complete the enclosed preregistration form and present it to the information/registration desk when you arrive for your child's appointment. This will help us to complete your registration quickly so that your child may be seen by his/her physician without delay.

Patients are seen in the order of their appointments, so please arrive promptly at your scheduled time. If your doctor is delayed by an emergency or other medical necessity, the nurse will notify you as soon as possible. If it is necessary to cancel your appointment, please give us at least two days notice. Some physicians may charge for missed appointments.

All patients under 18 years old **MUST** be accompanied by a parent or legal guardian. **CHILDREN MUST NOT BE LEFT UNATTENDED**.

Regarding payment and Insurance filing

If you do not have insurance, charges (lab, x-ray, supplies, etc) are payable at the time of service.

If you have assignable insurance, we will file your claim as a courtesy if the following information is supplied at the time of registration:

1. Insurance Company and group name.
2. Name and social security number of insured person.
3. Contract/policy/group number.
4. Address of the insurance company.
5. Completed claim form (if required by your insurance company or personnel office).

Your insurance card may supply most of the above information. Please present your card at registration. You are responsible for contacting your insurance company regarding payment and supplying them with additional information if needed. Should your insurance company fail to pay your claim within 45 days, you will be required to pay the balance of your account.

Many insurance plans now require pre-authorization before services (physician visits, tests) are rendered. Please follow the guidelines required by your insurance plan and obtain any necessary authorization **before** your appointment. This will avoid any denial of payment leaving you with the total bill.

Regarding Physician Billing

Your physician will bill separately for his/her services. If you have any questions about your physician's bill, please contact your physician.

Regarding Medicaid (including SSI)

You must bring your child's current Medicaid card and a valid **Community Care Referral** to registration. You obtain your Community Care Referral from the pediatrician your child is linked to through Medicaid. Medicaid requires that we receive a Community Care Referral for all children linked to a pediatrician. If you have any questions about Medicaid referrals you can contact Medicaid or your pediatrician.

Please include your child's social security number on the preregistration form, as this is required by Medicaid.

Regarding Children's Special Health Services

If you child participates in the State Children's Special Health Services Program (formerly Handicapped Children's Program), and is not covered by Medicaid, you must report to the CSHS office to obtain a written consult for any services (x-ray, lab, etc.) that are ordered during your physician visit. If a consult is not obtained, you will be expected to pay for services.

Please note that if your child was previously seen by another doctor's office or emergency room, and had x-rays taken, you must bring the x-rays with you to the appointment here at Children's to be seen.

Thank you for choosing Children's Hospital for your health care needs.

Department of Orthopaedic Surgery

CHILDREN'S HOSPITAL

Driving Directions to Children's Hospital

From the East (Slidell)

1. Take I-10 West toward New Orleans.
2. As you approach downtown New Orleans, get in the middle lane.
3. Take the US–90 West / US–90 Business W exit (exit number 234C) on the left towards Claiborne Avenue.
4. Keep right at the fork in the ramp and exit onto Claiborne Avenue.
5. Drive about 2 miles and turn left on Nashville Avenue.
6. Drive about 2 miles and turn right on Tchoupitoulas Street.
7. At the second stop sign you will see Children's Hospital at the corner of Tchoupitoulas Street and Henry Clay Avenue.

From the West (Baton Rouge)

1. Take I-10 East toward New Orleans.
2. After you pass through Kenner and Metairie, get in the right lane at the I–610 / I–10 junction. Stay right at I–10.
3. Take the US–61 / Airline Hwy / Carrollton Ave exit (exit number 232) and stay in the left lane.
4. Exit to left on Carrollton Avenue.
5. Stay on Carrollton Avenue all the way to the end (about 2.2 miles) and turn left at the levee onto Leake Avenue.
6. Stay on Leake Avenue through 4–way stop at Broadway until it turns left into Magazine Stree.
7. You will drive past Audubon Park (the Zoo will be on the right and the golf course on the left.)
8. Go right on Henry Clay Avenue at the first traffic light.
9. Children's Hospital is ½ mile ahead on the right after the stop sign.

From Covington (North Shore)

1. Take Hwy 190 South to Causeway Bridge ($3 toll) and cross bridge (24 miles.)
2. Stay on Causeway Blvd. South for about 4½ miles, all the way to the end. You will cross over Jefferson Highway and go straight until you reach the levee.
3. Turn left on River Road until you cross the railroad tracks.
4. Take an immediate right onto Leake Avenue and continue along the railroad tracks.
5. Stay on Leake Avenue through 4–way stop at Broadway until it turns left into Magazine Street.
6. You will drive past Audubon Park (the Zoo will be on the right and the golf course on the left.)
7. Go right on Henry Clay Avenue at the first traffic light.
8. Children's Hospital is ½ mile ahead on the right after the stop sign.

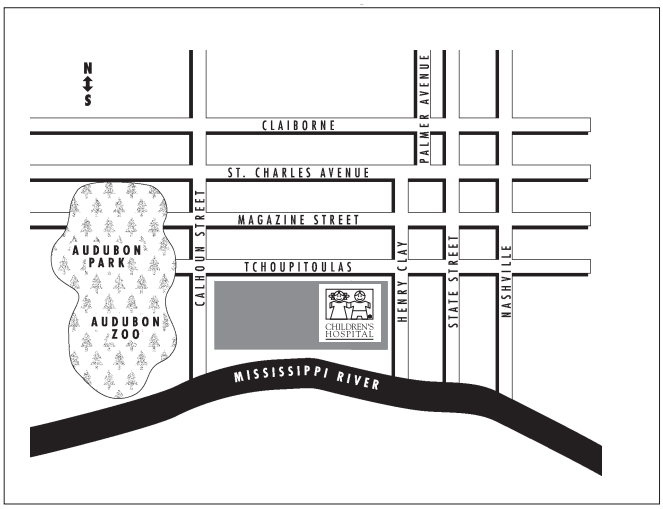
From the West Bank

1. Take the Crescent City Connection and exit on Tchoupitoulas Street (1st exit after river.) It will point you toward Uptown.
2. Stay on Tchoupitoulas for about 4 miles (follow detours as necessary.)
3. You will see Children's Hospital at the corner of Tchoupitoulas Street and Henry Clay Avenue.

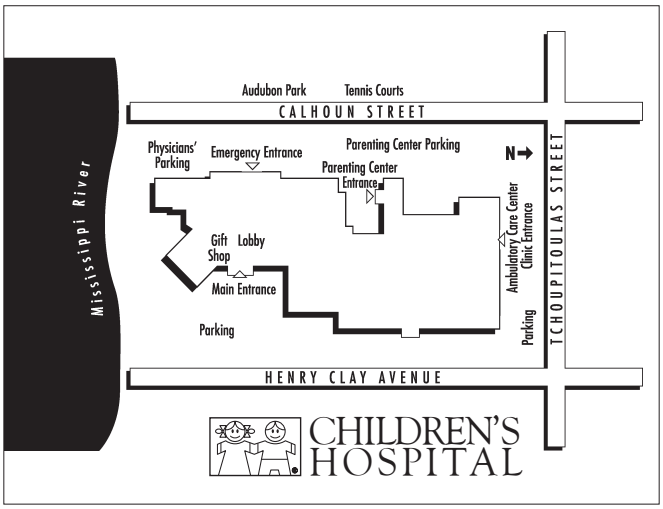
How to Get to Children's Hospital

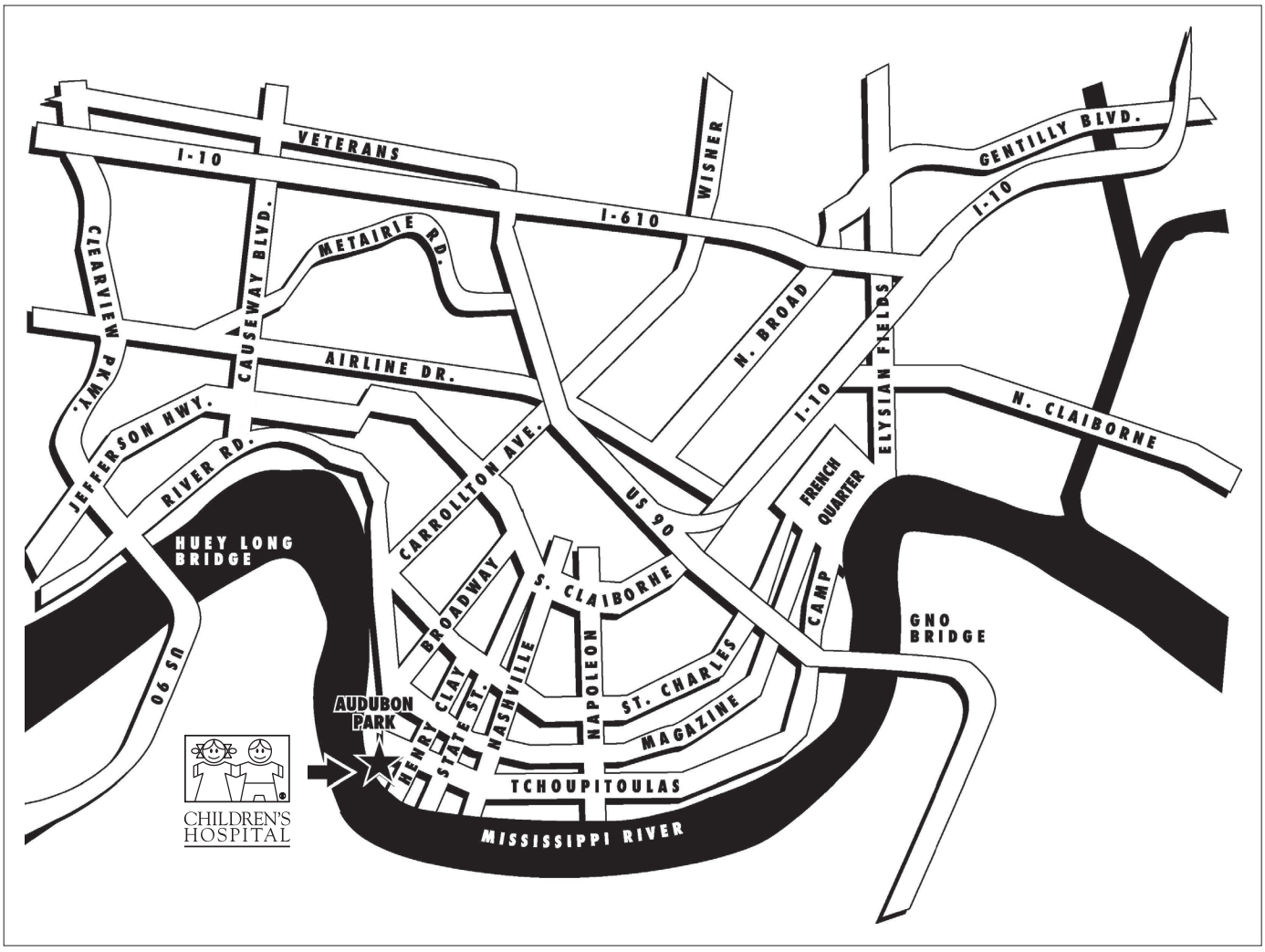
200 HENRY CLAY AVENUE • NEW ORLEANS, LA 70118 • 504-899-9511 • WWW.CHNOLA.ORG

Immediate Hospital Area



The Hospital





City Wide Area

Main Campus

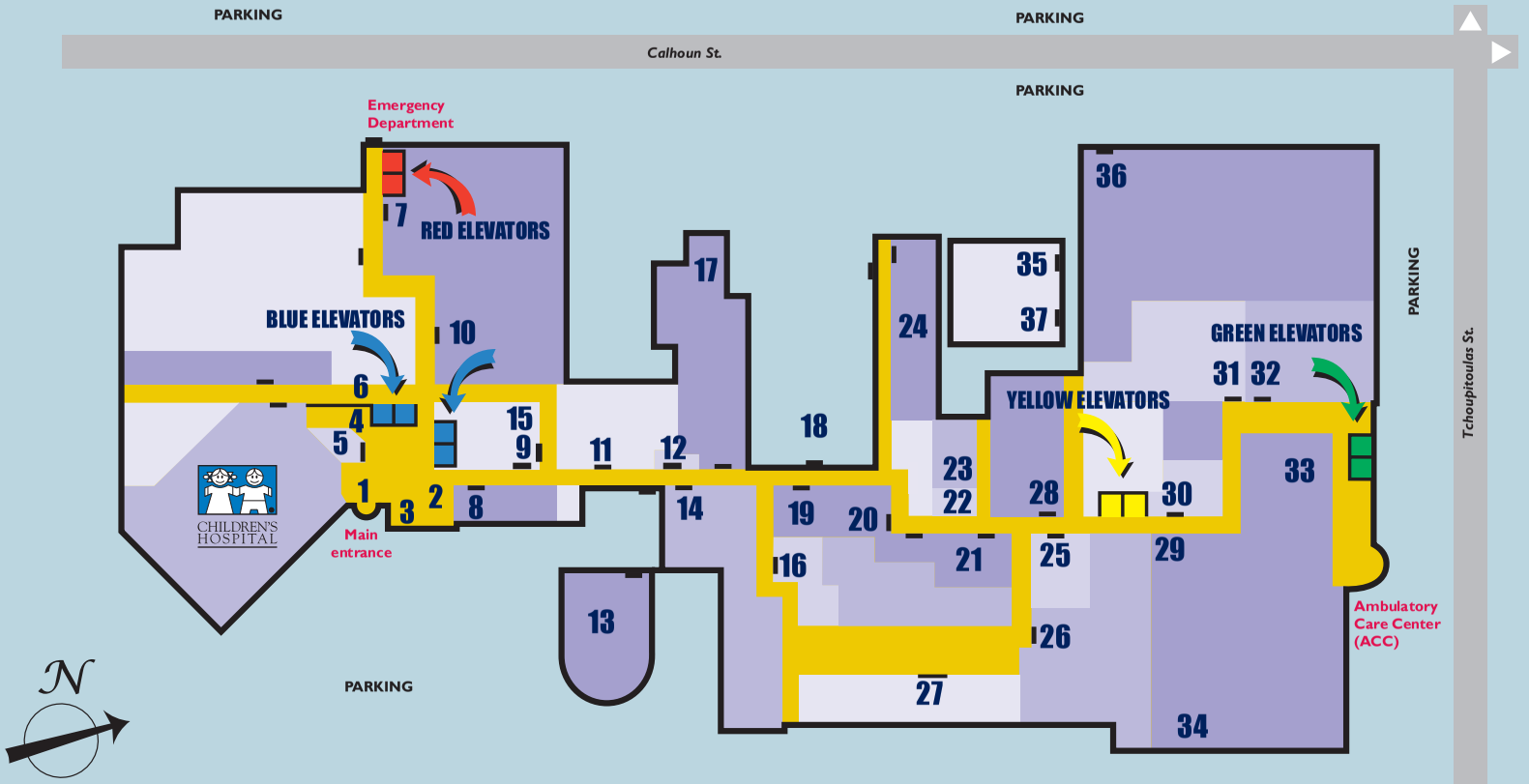
FIRST FLOOR

LEGEND

1 Main Entrance/Front Lobby
2 Information Desk
3 Chapel
4 Surgery Waiting
5 Gift Shop
6 ATM
7 Emergency Department
8 Admitting
9 Board Rooms A, B
10 Inpatient Radiology/MRI
11 Administration
12 Nursing Administration
13 Auditorium
14 CICU
15 Cashier
16 CICU Waiting
17 Teen center
18 Gazebo
19 Cafeteria
20 Vending Machines
21 Dining Area
22 School Room
23 Brace Shop
24 LSU Pediatrics
25 Child Life
26 Laboratory
27 Materials Management
28 Physical Therapy
29 Neurodiagnostics
30 Speech Therapy
31 Occupational Therapy
32 Outpatient Radiology/Cast Room
33 Ambulatory Care Center
34 Hematology/Oncology Clinic
35 Quality Assessment & Improvement
36 Research Institute for Children
37 Social Services

ELEVATORS (near)
Blue (Front Lobby)
Red (Emergency Department)
Yellow (Child Life)
Green (Ambulatory Care Center – ACC)

Children's Hospital is a Tobacco free campus



Registration Form

CHILDREN'S HOSPITAL

200 Henry Clay Avenue
New Orleans, LA 70118
(504) 899-9511 • www.chnola.org

HAS THE PATIENT RECEIVED SERVICES AT CHILDREN'S HOSPITAL OR ANY OF OUR CLINICS? ❑ YES ❑ NO

Patient's Information

PLEASE PRINT • MUST BE LEGAL BIRTH NAME • THIS INFORMATION IS REQUIRED

Last Name_____ Suffix_____
First Name _____ Middle _____
Date of Birth_____
Street Address _____
P.O. Box (if applicable)_____
City_____ State_____ Zip Code _____
Home Phone ( )_____
Cell Phone ( ) _____
Social Security # _____
Preferred language _____
Sex: ❑Male ❑Female

OPTIONAL: PLEASE SELECT ONE FROM THE FOLLOWING

Religion: _____
Ethnicity: ❑Hispanic / Latino ❑Not Hispanic / Latino
Race:
❑American Indian or Alaska Native
❑Asian
❑Black or African American
❑Native Hawaiian / Other Pacific Islander
❑White

Father's Information

PLEASE PRINT • MUST BE LEGAL BIRTH NAME • THIS INFORMATION IS REQUIRED

Last Name_____ Suffix_____
First Name _____
Middle _____
Street Address _____
City_____ State_____ Zip Code _____
Home Phone ( )_____
Cell Phone ( ) _____
E-mail address _____
Social Security #_____ Date of Birth _____
❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
Occupation _____
Employer _____
Work Address_____
City_____ State_____ Zip Code _____
Work Phone ( ) _____

Mother's Information

PLEASE PRINT • MUST BE LEGAL BIRTH NAME • THIS INFORMATION IS REQUIRED

Last Name _____
First Name _____
Middle _____
Street Address _____
City_____ State_____ Zip Code _____
Home Phone ( )_____
Cell Phone ( ) _____
E-mail address _____
Social Security #_____ Date of Birth _____
❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
Occupation _____
Employer _____
Work Address_____
City_____ State_____ Zip Code _____
Work Phone ( ) _____

Person Responsible for Bill

PLEASE PRINT • MUST BE LEGAL BIRTH NAME •THIS INFORMATION IS REQUIRED

Name _____
Relationship to Child_____ Phone _____
Employer _____
Address_____
City_____ State_____ Zip Code _____
Social Security No. _____

Emergency Contact (Other than Parent)

PLEASE LIST THE NAME OF A RELATIVE OR FRIEND THAT DOES NOT LIVE WITH YOU AND CAN BE CONTACTED IN CASE OF AN EMERGENCY.

Name _____
Relationship to Patient _____
Street Address _____
City_____ State_____ Zip Code _____
Phone: ( ) _____

Insurance Information

Name of Insured _____
Insured Date of Birth: _____
Insured Social Security #: _____

FIRST POLICY:

Insurance Company _____
Phone # to verify Insurance coverage ( ) _____
Policy #_____
Does your insurance need to be pre-certified? ❑ Yes ❑ No

SECOND POLICY:

Insurance Company _____
Phone # to verify Insurance coverage ( ) _____
Policy #_____
Does your insurance need to be pre-certified? ❑ Yes ❑ No
Name of Insured _____

Medicaid/CCN Bayou Plan

Medicaid #_____
Parish/County_____ State _____
Name of Worker _____

Referral Information

Child's Pediatrician _____

Who referred the patient to Children's Hospital:
Physician's Name _____
Health Facility's Name _____

Parent/Guardian/Caregiver's Signature	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	:

OFFICE USE ONLY

Medical Rec. #_____ Acct. _____
Physician_____ Service _____
Date_____ Time _____

CHILDREN'S HOSPITAL

Department of Orthopaedic Surgery

Date _____

Name of Patient _____ Date of Birth _____

❑ Male ❑ Female Who are you seeing today? _____

Family/Primary Care Physician _____ City _____ State _____

Referring Physician _____ City _____ State _____

Chief Complaint/Reason for visit _____

Spine

Is patient being seen for their SPINE? ❑ Yes ❑ No

History of scoliosis? ❑ Yes ❑ No

If yes, was their scoliosis found by school screening? ❑ Yes ❑ No

Or by Pediatrician? ❑ Yes ❑ No

Has patient ever been treated for their scoliosis or has any other physician evaluated patient for their scoliosis? ❑ Yes ❑ No Explain _____

Was there an injury to the spine, i.e. lifting, pushing, pulling type of activity ❑ Yes ❑ No

Explain _____

If patient is female, has she started her menstrual cycle? ❑ Yes ❑ No If yes, how long? _____

Injury

Is presenting problem an INJURY? ❑ Yes ❑ No

If yes, how did injury occur? _____

Date of Injury _____ What body part is injured? _____

Injury (continued)

Any other previous injuries? _____

Has patient been treated for this injury? ❑ Yes ❑ No

Describe type of treatment (splint, cast, crutches, knee immobilizer, medication given, any surgeries) for this injury _____

Pain Without Injury

Is presenting problem PAIN without an injury? ❑ Yes ❑ No

If yes, approximate date pain began _____

Location of pain_____

Quality of pain (sharp, dull, throbbing, burning, does pain radiate down arms or legs?) Explain.

_____

_____

Is pain getting better? ❑ Yes ❑ No

How severe is pain? (Circle one.) 1 2 3 4 5 6 7 8 9 10

Is pain constant? ❑ Yes ❑ No Does pain come and go? ❑ Yes ❑ No

Is pain worse with activities? ❑ Yes ❑ No If yes, what type of activities aggravate pain? (Sitting, standing, walking, bending, lifting, pulling, squatting)_____

Any bowel/bladder changes? ❑ Yes ❑ No

Is pain relieved with rest? ❑ Yes ❑ No

Is pain relieved with Motrin, Aleve, Tylenol or other medicines? ❑ Yes ❑ No If yes, which one(s)?_____

Has patient ever had steroid therapy? ❑ Yes ❑ No

Does patient have a family history reaction to Anesthesia ❑ Yes ❑ No If yes, please explain.

_____

Is patient on any blood thinners? (Coumadin/Warfarin/Lovenox/Plavix,Aspirin) ❑ Yes ❑ No

Immunizations: are they up to date? ❑ Yes ❑ No

Medications currently taking _____

_____

Allergies to medications_____

Past Medical History

Please list all medical problems _____

_____

Has patient been hospitalized before? ❑ Yes ❑ No If yes, reason for hospitalization _____

_____

_____

Has patient had surgery before? ❑ Yes ❑ No If yes, describe _____

_____

Family History

Mother _____

Father _____

Siblings _____

Social History

Student (please circle) Full time or Part time. Grade _____

Name of School_____

Hobbies/Sports _____

_____

Developmental History

Was patient full term? ❑ Yes ❑ No If not, how many weeks gestation?_____

Birth weight _____ pounds _____ ounces

Was patient born by ❑ C-section? or by ❑ Vaginal delivery?

Were there any difficulties/problems with pregnancy? ❑ Yes ❑ No

If yes, please explain what problems there were_____

_____

Was there a breech in pregnancy? ❑ Yes ❑ No

At what age did patient Sit Up _____ Crawl _____

Stand _____ Walk _____

Review of Systems (Please check positive responses)

General:
- ❑ None
- ❑ Fever
- ❑ Chills
- ❑ Weight loss
- ❑ Fatigue
- ❑ Infections

Skin:
- ❑ None
- ❑ Rashes
- ❑ Lumps
- ❑ Sores
- ❑ Itching
- ❑ Dryness
- ❑ Color change in skin, hair or nails

Head:
- ❑ None
- ❑ Headaches
- ❑ Head Injury
- ❑ Dizziness

Neck:
- ❑ None
- ❑ Lumps
- ❑ Pain
- ❑ Swollen Glands
- ❑ Stiffness

Chest:
- ❑ None
- ❑ Cough
- ❑ Cystic Fibrosis
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Deformity

Heart:
- ❑ None
- ❑ Chest pain
- ❑ High Blood Pressure
- ❑ Rheumatic fever
- ❑ Heart murmur
- ❑ Palpitations
- ❑ Difficulty breathing
- ❑ Edema
- ❑ Blue Color

Ears:
- ❑ None
- ❑ Deafness
- ❑ Ringing
- ❑ Vertigo
- ❑ Earaches

Nose:
- ❑ None
- ❑ Sinus Problems
- ❑ Discharge
- ❑ Itching
- ❑ Hay Fever
- ❑ Nose Bleeds

Mouth:
- ❑ None
- ❑ Tooth Decay
- ❑ Cleft Palate/Lip
- ❑ Bleeding
- ❑ Sore Throat

Eyes:
- ❑ None
- ❑ Blindness
- ❑ Glasses/Contacts
- ❑ Pain
- ❑ Redness
- ❑ Lazy Eye

Musculoskeletal:
- ❑ None
- ❑ Abnormal Walking
- ❑ Muscle Pain
- ❑ Joint Pain
- ❑ Stiffness
- ❑ Arthritis
- ❑ Gout
- ❑ Backache

Hematologic:
- ❑ None
- ❑ Anemia
- ❑ Easy bruising
- ❑ Easy bleeding
- ❑ Past blood transfusions

Neurologic:
- ❑ None
- ❑ Developmental Problems
- ❑ Fainting
- ❑ Blackouts

Gastrointestinal:

- ❑ None
- ❑ Trouble Swallowing
- ❑ Heartburn
- ❑ Appetite
- ❑ Nausea
- ❑ Vomiting
- ❑ Regurgitation

- ❑ Seizures
- ❑ Weakness
- ❑ Paralysis
- ❑ Numbness
- ❑ Tingling
- ❑ Tremors
- ❑ Involuntary movements
- ❑ Meningitis

Review of Systems (Continued)

Gastrointestinal (cont.):

- ❑ Vomiting Blood
- ❑ Indigestion
- ❑ Rectal Bleeding
- ❑ Constipation
- ❑ Diarrhea
- ❑ Abdominal pain
- ❑ Jaundice
- ❑ Food intolerance
- ❑ Hepatitis

Psychiatric:

- ❑ None
- ❑ Nervousness
- ❑ Tension
- ❑ Memory loss
- ❑ Depression

Urinary:

- ❑ None
- ❑ Painful urination
- ❑ Bloody urine
- ❑ Urine infections
- ❑ Stones
- ❑ Bed Wetting

Please explain checked items. _____

_____

_____

_____

_____

List any congenital abnormalities: _____

_____

Is there any medical information of importance not indicated on this form? ❑ Yes ❑ No

If yes, please explain _____

_____

Parent/Guardian's Signature	**Date** / /
Parent/Guardian's Signature	**Date** / /
Reviewed by:	**Date** / /