

W. Daniel Williamson, M.D. and Anson J. Koshy, M.D.
Developmental Pediatricians
Dan L. Duncan Children's Neurodevelopmental Clinic
Children's Learning Institute
University of Texas Health Science Center at Houston
6655 Travis, Suite 880 • Houston, Texas 77030

To schedule an appointment with one of our physicians:

- Complete the Patient Information Form (PIF, attached). All information requested is important. However, don't wait to get things like Apgar scores or head size. Forms without clearly stated concerns on page 3 will be returned to you for clarification. Sometimes it is easier to use a computer and attach the page(s) rather than use the lines on that page.
- Returning patients must also send the PIF in order to be scheduled. The *top* of page 2 requesting history of pregnancy and development can be omitted since that will not have changed. But the remainder of the form must be completed, even if the information has not changed since the last appointment.
- Make your non-refundable \$150 check payable to "Developmental Pediatrics." Note that this is a **prepayment** of the total fee, not an additional fee.
- **MAIL** the PIF, any recent testing, and your check for \$150 to:

KATRINA BRIGHT, CLINIC MANAGER
6655 Travis, Suite 880
Houston, Texas 77030

- You may drop the forms off at our office between 8 a.m. and 12 p.m. or 1 p.m. and 5 p.m. We will not be able to schedule the appointment at that time since the information must be reviewed first.
- We will call you within a week after receiving this PIF.

WE DO NOT ACCEPT FAXED FORMS. NO EXCEPTIONS.

- You can assume your child's appointments will be initially scheduled 8 to 12 weeks from this date. However, we do keep a **WAITING LIST** of people *who have returned all forms* and wish to be called if an earlier appointment becomes available. (And this does happen!)
- Within two weeks after your child's appointments are scheduled, you will receive an envelope with forms (behavioral and/or developmental questionnaires) for both you and your child's teacher (if appropriate) to complete. It is these forms we must receive before we can put your child's name on the waiting list. A letter enclosed with these forms will give a date before which forms must be in our office. Do not think of this as a due date. Return your forms as soon as possible.
- Remember we **do not file** with your insurance company. We will collect **payment in full** at the time of each scheduled appointment by cash, check, VISA, MasterCard, Discover, or American Express. You will be provided with a statement to file with your insurance at either the second appointment or in the mail with your report.
- Still have questions? Call *Katrina* 713-500-8300, option 7.

**The Dan L. Duncan Children's Neurodevelopmental Clinic
PATIENT INFORMATION FORM**

Child's Legal Name:			Nickname?		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Age: ____	Grade: ____		
Adopted? <input type="checkbox"/> No <input type="checkbox"/> Yes, at age ____		Ethnicity:	Language(s) spoken in home:		

Who referred you to our clinic? _____
Reason for the evaluation: _____

I. FAMILY INFORMATION

A. Parents

Parent's Name:			Age: ____			Parent's Name:			Age: ____		
Address:						Address: (if different)					
City:		State:		Zip:		City:		State:		Zip:	
Home Phone:						Home Phone:					
Cell:						Cell:					
Email:						Email:					
Occupation:			Highest Degree:			Occupation:			Highest Degree:		
Year Married:			If Divorced, Year:			Year Married:			If Divorced, Year:		

B. Step Parents (if applicable)

Name:			Age: ____			Name:			Age: ____		
Occupation:			Highest Degree:			Occupation:			Highest Degree:		
Year Married:			If Divorced, Year:			Year Married:			If Divorced, Year:		

C. Brothers and Sisters

Name	Sex	Age	Where living, if out of child's home	Relationship to child (full, half, step)

D. Family History

Check if yes. Relation to child: Sibling, parent, grandparent, aunt, uncle, cousin			
	Relation		Relation
<input type="checkbox"/> ADD/ADHD		<input type="checkbox"/> Depression	
<input type="checkbox"/> Learning Disability (e.g., Dyslexia)		<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Speech/Language Problems		<input type="checkbox"/> Bipolar Disorder	
<input type="checkbox"/> Autism Spectrum		<input type="checkbox"/> Alcohol/ Substance Abuse	
<input type="checkbox"/> Developmental Delay/ Intellectual Disability		<input type="checkbox"/> Sudden Cardiac Death/Cardiomyopathy	

A. Pregnancy History

Mom's age at Delivery _____	Mom total # Pregnancies _____	Patient was pregnancy # _____	# of Miscarriages _____	# living Children _____
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B. Medical Conditions during pregnancy with this child:

Healthy, no problems Skip to C. **If problems, complete below:**

Type	Check if Yes	Month of Pregnancy	Description
Illness/Infections	<input type="checkbox"/>		
Hypertension	<input type="checkbox"/>		
Bleeding	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>		
Preterm labor	<input type="checkbox"/>		
Exposure to toxic/X-ray	<input type="checkbox"/>		
Medications	<input type="checkbox"/>		
Alcohol/Cigarettes/Drugs	<input type="checkbox"/>		
Other Problems	<input type="checkbox"/>		

C. Labor and Delivery

Was baby Full Term? Yes No

If no, premature delivery occurred at _____ weeks of pregnancy.

Delivery was.... (Check all that apply below)

<input type="checkbox"/> Vaginal	<input type="checkbox"/> Head first	<input type="checkbox"/> Breech
<input type="checkbox"/> Forceps/ Vacuum	<input type="checkbox"/> C-Section, Scheduled	<input type="checkbox"/> C-Section, Emergency
Birth Weight: _____ lbs. _____ ozs.	Length: _____ inches	
Apgar Scores: 1 min: _____ 5 min: _____	Days in Hospital: _____	Head Circumference: _____

D. Neonatal History

Normal Skip to E. **If problems, complete below:**

	Check if Yes		Check if Yes
Needed help breathing?	<input type="checkbox"/>	Had brain hemorrhage?	<input type="checkbox"/>
Had jaundice during first week?	<input type="checkbox"/>	Had seizures?	<input type="checkbox"/>
Had surgery shortly after birth?	<input type="checkbox"/>	Had difficulty feeding (sucking, swallowing)?	<input type="checkbox"/>
Other problems:			

E. Developmental History

Skill/Milestone	Age in months when achieved	Comments?
Slept through the night		
Sat alone		
Crawled		
Stood alone		
Walked alone		
Pedaled tricycle		
Rode bicycle without training wheels		
Said first word (other than "mama" or "dada")		
Spoke in simple phrases		
Spoke in mostly complete sentences		
Completed daytime toilet-training		
Completed nighttime toilet-training		

III. MEDICAL HISTORY of CHILD

A. Illnesses/Injuries Healthy Skip to B. If problems, complete below:

	Check if Yes	If yes, Age		Check if Yes	If yes, Age
Chronic ear infections	<input type="checkbox"/>		Heart Problems	<input type="checkbox"/>	
Recurrent Strep Throat	<input type="checkbox"/>		IBD/Celiac/GERD	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>		Cancer	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>		Other Illnesses	<input type="checkbox"/>	
Dizziness/fainting	<input type="checkbox"/>		Head Injury/concussion	<input type="checkbox"/>	
Seizures//Epilepsy	<input type="checkbox"/>		Other Illnesses or Injuries	<input type="checkbox"/>	
Describe any health concerns:					

B. Surgeries

Type	Age	Complications/Results

C. Behavioral Health Diagnosis

	Check if Yes	If yes, Age		Check if Yes	If yes, Age
Anxiety	<input type="checkbox"/>		Developmental Delay	<input type="checkbox"/>	
Depression	<input type="checkbox"/>		Fine or Gross Motor Delay	<input type="checkbox"/>	
Bipolar Disorder	<input type="checkbox"/>		Autism Spectrum	<input type="checkbox"/>	
ADD/ADHD	<input type="checkbox"/>		Tourette's or Tic Disorder	<input type="checkbox"/>	
Learning Disorder	<input type="checkbox"/>		Speech or Language Delay	<input type="checkbox"/>	

D. Vision & Hearing

	Year	Results?	
Last vision check?			Wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last hearing check?			Hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No

E. Medication History

List prescription medication child has taken on a regular basis (i.e., stimulants, antidepressants, anticonvulsants):

Medication	Dose	Reason for Medication	Currently taking? (circle one) Yes/No
			Yes/No
			Yes/No
			Yes/No

IV. EDUCATIONAL HISTORY

A. Childcare/Preschool:

Complete section if child age 7 or less. If child is 8 years or older, skip to B

Has your child ever attended infant/toddler childcare, Mother's Day Out, or Pre-K?

Yes No If yes, please complete below:

Name of School/Childcare/MDO/Pre-K	Ages attended	Reason for leaving

B. Grade School: Current grade _____

	School Name	Type of Class: Regular, G/T, Special Education, 504
Elementary		
Middle		
High School		

If retained in any grades, please describe: _____

C. Specialized Services

Has your child ever received services at school for a disability? No If no, skip to D

- Yes No Early Intervention Services (birth – 3yrs.)?
 Yes No Preschool Programs for Children with Disabilities (ages 3-5)
 Yes No Testing or intervention services (ages 6 + yrs.)?

Qualifying conditions:	<input type="checkbox"/> Speech <input type="checkbox"/> LD <input type="checkbox"/> Autism <input type="checkbox"/> Other Health <input type="checkbox"/> Behavioral <input type="checkbox"/> 504
What services/accommodations is your child receiving now?	

D. Community Interventions

Has your child ever received interventions in the community? No If NO, skip to V

If yes:		
Type of service	Ages received	Outcome?
Speech therapy		
Occupational therapy		
Physical therapy		
Developmental teaching		
Applied Behavioral Analysis (ABA)		
Tutoring		
Psychological therapy		
Other		

V. FAMILY STRESSORS: List any stressors that your child/family has experienced in the past two years (e.g., death of pet, death/illness of family members, school performance issues, financial stresses):

VI. ANYTHING ELSE? If there is anything else that you feel is important for your clinician to know about your child or your family, please describe below.

Form completed by: _____ Relation to Child: _____

**Authorization to Disclose Protected Health Information
FROM**

**W. Daniel Williamson, M.D. or Anson J. Koshy, M.D.
Dan L. Duncan Children's Neurodevelopmental Clinic
Children's Learning Institute
University of Texas Health Science Center at Houston
6655 Travis, Suite 880 • Houston, Texas 77030**

This form is to confirm your authorization to disclose your child's protected health information to his/her **pediatrician of record**. You may request non-release with this form by writing "none" in the "This information may be disclosed TO..." paragraph below.

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name (first, middle, last and nickname): _____

Date of Birth: _____

I authorize the following to disclose the above individual's health information:

W. Daniel Williamson, M.D.
Developmental Pediatrician
6655 Travis, Suite 880
Houston, Texas 77030

This information may be disclosed TO my child's pediatrician:

Name: _____

Address: _____

Purpose of disclosure: To share medical records.

Please release the following:

<input type="checkbox"/>	Medical Evaluation report
<input type="checkbox"/>	Laboratory Results
<input type="checkbox"/>	Other specified: _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient/patient representative is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of protected health information described in this form with the people and/or organizations named in this form. If I have questions about disclosure of my health information, I may contact Sally Dunton, Office Manager/Privacy Official, for Developmental Pediatric Associates.

Patient or Parent's/Guardian's Signature: _____

Patient or Parent's/Guardian's Printed Name: _____

Relationship to Patient: _____

Date: _____

We do NOT share our records with any school or any other professional without your specific separate authorization to do so. That authorization will be obtained if/when necessary. If you choose, you may complete that authorization at the time of the parent conference or after you have reviewed the report. You will receive an exact copy of the original report that you can copy and share as you wish.

INSURANCE INFORMATION FORM

This information is helpful to us but is not a requirement *unless* we have an agreement in place with a contracting agency such as Kelsey-Seybold. In that case you must complete all information before we can schedule.

PATIENT INFORMATION

Full Name (please print) _____ Date of Birth _____ Sex (circle) M F

INSURANCE INFORMATION

ID Number of the Insured Party _____

Insured's Name _____ Circle: Male Female

Insured's Address _____

Home Telephone Number _____

Policy/Group Number(s) _____

Insured's Date of Birth _____ Social Security Number _____

Employer's Name _____

Insurance Plan Name _____

Complete Claims Address _____

Insurance Plan Telephone Number _____

Patient Relationship to Insured (circle) Child Self Other

YOU MUST SIGN ONE OF THE FOLLOWING STATEMENTS

I hereby attest that the above policy is the only insurance coverage available to the patient described and that no co-benefits are available from any source.	
I hereby attest that there is additional coverage available to the patient described and that information is provided below.	

SECOND INSURANCE POLICY/CO-BENEFITS

ID Number of the Insured Party _____

Insured's Name _____ Circle: Male Female

Insured's Address _____

Home Telephone Number _____

Policy/Group Number(s) _____

Insured's Date of Birth _____ Social Security Number _____

Employer's Name _____

Insurance Plan Name _____

Complete Claims Address _____

Insurance Plan Telephone Number _____

Patient Relationship to Insured (circle) Child Self Other

REFERRING DOCTOR

Full Name _____

Address _____

Telephone Number _____