

W. Daniel Williamson, M.D.

Developmental Pediatrician

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 Dr. Williamson:

- 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:

Developmental Pediatrics (Attn: Katrina Bright, Clinical Manager on the envelope)
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.
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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 check, VISA, MasterCard, Discover, or American Express. **WE DO NOT ACCEPT CASH.** 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 at 713-500-8300, option 7.

The Dan L. Duncan Children's Neurodevelopmental Clinic
FOLLOW-UP VISIT PATIENT INFORMATION FORM

Child's Legal Name:			Nickname?
Last Evaluated:	Date of Birth:	Age: ____	Grade: ____

Reason for re-evaluation: _____

I. FAMILY INFORMATION: PLEASE UPDATE IF CHANGED

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

C. Other people child currently lives with (siblings, relatives):

Name	Age	Relationship to child (full, half, step sibling)

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

Appgar 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. EDUCATIONAL HISTORY SINCE LAST EVALUATION

A. Current grade _____

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

If retained in any grades, please describe: _____

B. Specialized Services Since Last Visit

Has your child received testing or intervention services at school for a disability?

No If no, skip to D. If yes, please complete.

Testing—what were results?	
What services/accommodations is child receiving now?	
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

C. Community Interventions

Has your child received interventions in the community? No; skip to V. If yes, complete below.

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

IV. 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):

V. 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: _____

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: _____ Group Number _____

Insured's Name: _____ Sex (Circle): Male Female

Insured's Address: _____

Home Telephone Number: _____ Other Number: _____

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 a 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: _____ Group Number _____

Insured's Name: _____ Sex (Circle): Male Female

Insured's Address: _____

Home Telephone Number: _____ Other Number: _____

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: _____