

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
(713) 500-8300 **FAX (713) 500-8289**

PATIENT INFORMATION FORM

For Office Use Only Date Returned: _____

CHILD'S LEGAL NAME _____ Sex _____ Birthdate _____
(first) (middle) (last)

BY WHAT NAME IS THE CHILD CALLED? _____

Child's Address _____
(street address) (city, state) (ZIP)

MOTHER'S FULL NAME _____ Birthdate _____ Age _____
(first) (maiden) (last)

Mother's Address _____
(street address) (city, state) (ZIP)

Education Completed Through: _____ Home Phone _____

Cell Phone _____

Occupation _____ Employer _____ Work Phone _____

FATHER'S FULL NAME _____ Birthdate _____ Age _____
(first) (MI) (last)

Father's Address _____
(street address) (city, state) (ZIP)

Education Completed Through: _____ Home Phone _____

Cell Phone _____

Occupation _____ Employer _____ Work Phone _____

STEPMOTHER'S FULL NAME _____ Birthdate _____ Age _____

Occupation _____ Employer _____ Work Phone _____

STEPFATHER'S FULL NAME _____ Birthdate _____ Age _____

Occupation _____ Employer _____ Work Phone _____

Parents' Marital Status: (Circle One) Married Separated Divorced Widowed Single

With whom does child live? (Relationship and Name, if not given above) _____

BROTHERS AND SISTERS (List ALL at home or away)

Name	Date of Birth	Occupation or School	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

There is a family history of (please circle): developmental problems, learning disabilities, dyslexia, attention deficit disorder, depression, bi-polar disorder, obsessive-compulsive disorder, anxiety disorder, autism, PDD-NOS, sudden cardiac death, cardiomyopathy, other (describe) _____

PREGNANCY

Mother's age at delivery _____ Mother's total number of pregnancies _____ Patient was pregnancy number _____

Number of miscarriages _____ Number of living children _____

During this pregnancy: Weight gain _____ lbs. medications _____ alcohol _____
cigarettes _____ drugs _____ infections _____ other problems _____

Labor: spontaneous _____ induced _____ other _____

Delivery: vaginal _____ forceps _____ vacuum _____ C-section, scheduled _____ C-section, emergency _____

Place of delivery: _____

Gestational age: _____ Due date: _____ Birth weight: _____ Height: _____ Head size: _____

After birth: Apgar scores _____ Did (s)he breathe promptly? _____ Was oxygen required? _____

Was incubator required? _____ Was (s)he jaundiced? _____ Age at time of discharge? _____

DEVELOPMENT (At what age did each of the following occur?)

Sat alone _____	Fed self _____
Crawled (using hands and knees) _____	Talked single words _____
Walked alone _____	Talked sentences _____
Rode tricycle _____	Bowel control _____
Rode bicycle _____	Bladder control _____

MEDICAL (Please check the following.)

	Yes	No	Do Not Know
Does (s)he appear to hear well?.....	_____	_____	_____
Does (s)he appear to see well?.....	_____	_____	_____
Does your child have a history of chronic ear infections?.....	_____	_____	_____
Does your child have seizures (convulsions)?.....	_____	_____	_____
Does your child have allergies?.....	_____	_____	_____
Does your child have difficulty eating?.....	_____	_____	_____
If yes, what kind? Vomiting, gagging, chewing, swallowing, behavior, self-feeding, amount of food?.....	_____	_____	_____
Does (s)he have heart problems, exercise intolerance, etc.....	_____	_____	_____
What medications does your child take?.....	_____	_____	_____

Give the names of previous hospitals, doctors, or therapists, that have seen the child. (See page 3 to provide school contacts.)

Name of child's *PRIMARY* doctor or clinic: _____

Complete Address: _____

Phone: (including area code) _____

Name: _____ When Seen? _____

Address _____

Name: _____ When Seen? _____

Address _____

Name: _____ When Seen? _____

Address _____

Name: _____ When Seen? _____

Address _____

(If additional space is needed, continue on the back of this page or attach a page.)

SCHOOL

School District In Which You Reside: _____

County In Which You Reside: _____

Please answer the following questions if they are applicable to your child:

Child's present school: _____ Grade: _____

Address _____ Phone _____

Has your child been tested at school? _____

What were you told about the results? _____

What special services does your child receive at school? _____

What Special Education label(s) (e.g., LLD, Speech Handicapped, or MR) are used to describe your child's problem?

Does your child receive any private help outside of school? _____

If so, with whom, what, and how often? _____

Please describe your concerns about your child. If you were referred by a professional please give the name. What questions would you like answered with this evaluation? If needed, continue on the back of this page or attach a page to this.

Name of person completing this form: _____

Relationship to child: _____ Date form was completed: _____

Authorization to Disclose Protected Health Information
FROM
W. Daniel Williamson, 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:

	Medical Evaluation report
	Laboratory Results
	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
PROVIDE ALL REQUESTED INFORMATION

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 _____

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.

TO SCHEDULE AN APPOINTMENT WITH DR. WILLIAMSON

- Complete the Patient Information Form (PIF). 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 \$50 check payable to "Developmental Pediatrics."
- **MAIL** the PIF, any recent testing, and your check for \$50 to:

Sally Dunton, 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 48 hours after receiving forms.

WE DO NOT ACCEPT FAXED FORMS. NO EXCEPTIONS.

- You can assume your child's appointments will be initially scheduled at least 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.
- Still have questions? Call Sally at 713-500-8300, option 7.