

New Patient Forms

Chart# _____

Please circle the physician you have chosen:

J. Todd Brodbeck, D.O.

Amanda M. Guetersloh, M.D.

Cheryl C. Landry, M.D.

Brooks T. Rogers, M.D.

Child's Name _____ Sex _____

Date of Birth ____/____/____ Age _____ SS# _____

Address _____ City _____ State _____ Zip _____

Regular Pharmacy used _____

Mother's Name _____ DOB _____ SS# _____

Address (If different from child) _____

Home Phone _____ Cell Phone _____ DL# _____

Employment _____ Work Phone _____

Father's Name _____ DOB _____ SS# _____

Address (if different from child) _____

Home Phone _____ Cell Phone _____ DL# _____

Employment _____ Work Phone _____

Insurance Company _____ Policy Holder _____

ID# _____ Group# _____ Co-Payment\$ _____

Are Immunizations /Well Child Exams covered by your insurance policy? Yes _____ No _____

Emergency Contact _____ Phone# _____

Who may we thank for referring you to our office? _____

I understand that any service provided by West Texas Pediatrics, LLP not covered by my insurance plan would be my responsibility. West Texas Pediatrics will file my insurance as a courtesy but ultimately the responsibility of the insurance and the account will be my own.

I authorize the release of medical information necessary to pay my claims provided by this office. In the event of an assigned claim, I authorize payment to be made directly to the provider of services.

I authorize West Texas Pediatrics, LLP to provide medical care to my child listed above.

I acknowledge receipt of the notice of privacy practices of West Texas Pediatrics, LLP.

Authorized Signature

Relationship to Patient

Today's Date

Child's Name _____

Chart# _____

Medical History

Prenatal Information:

When you were pregnant with this child, did you have?

High Blood Pressure _____ Measles _____ Chicken Pox _____ Mumps _____ Other _____?

What is your blood type? _____ How long did labor last from onset of pains until birth? _____

Were there any complications with delivery? If so, what? _____

Did you have a Vaginal Delivery, C-Section, or Forceps Delivery? _____

Neonatal Information:

Was your child premature? _____ If so, how much? _____

Date of Birth _____ Baby's Birth Weight _____

Did baby cry immediately when born? _____ Was oxygen required for baby? _____

During the hospital stay did baby have: Jaundice _____ Rash _____ Blue Spells _____

Convulsions _____ Fever _____ Other _____

Did the baby have difficulty sucking or crying when first brought to you? _____

Was the baby breast fed? _____ Formula Fed? _____ Were vitamins started? _____ when? _____

Family History:

How many brothers and sisters does this child have? _____ ages: _____

Do any family members have any chronic illnesses or congenital abnormalities? _____

Is either of the parents deceased? _____

Has either parent or any relative in either family has: Tuberculosis _____ Diabetes _____ Rheumatic Fever _____

Asthma _____ Allergies _____ Convulsive Disease _____ Anemia _____ Bleeding Disorders _____

Do any illnesses run in either family? _____

Have any of your children that were born alive subsequently died? _____

Child's Name _____

Chart# _____

Childhood Diseases:

Has your child had?

Measles _____ Mumps _____ Chicken Pox _____ German Measles _____ Roseola _____ Scarlet Fever _____

Whooping Cough _____ Polio _____ Rheumatic Fever _____

Has your child had any serious medical illnesses? _____

Has your child had allergies to medications? _____ If so, what? _____

Has your child had any other allergies? _____ if so, please name. _____

Has your child had any operations? _____ When? _____

Has your child ever had any serious injuries? _____

Has your child ever been hospitalized? _____ Where? _____

Is your child currently taking any medication? _____ if so, please name. _____

Systemic Review: (The questions below pertain to any time since birth.)

Eyes: Has your child ever had trouble seeing? _____

Have your child's eyes ever been noted to cross? _____

Ears: Has your child ever had frequent ear infections or chronic ear infections? _____

Nose: Has your child ever had frequent nose bleeds? _____

Throat: Has your child ever had trouble swallowing? _____

Heart: Has a heart murmur ever been heard on your child? _____

Has your child ever had a blue spell, swollen ankles or swollen joints? _____

Lungs: Has your child ever had pneumonia, tuberculosis, or pleurisy? _____

Does your child have a chronic cough or night sweats? _____

Does your child tire easily? _____

Does your child cough up blood? _____

Abdomen: Has your child ever had yellow jaundice? _____

Black Bowel movements? _____

Worms? _____

Frequent Abdominal Pain? _____

Marked weight loss? _____

Urinary Tract: Does your child have any pain, burning, frequency, or urgency with urination? _____

Has there ever been blood or change in color in urine? _____

Have you ever noticed any swelling around the child's eyes and ankles? _____

Extremities: Has your child had weakness, limp or paralysis or arms or legs? _____

Has your child ever worn braces or corrective shoes? _____

Neurological: Has your child ever had Headaches _____ Fits or Convulsions _____

Dizziness _____ Fainting _____ Black Out Spells _____