appointment checklist

Dear parents:

The staff of Cook Children's Pediatric Gastroenterology (GI) and Nutrition Clinic appreciates your selection of our physicians to serve you and your child's needs. Our goal is to provide the very best possible care to each patient that we see. We encourage parents to ask questions, offer suggestions and participate in the planning of their child's care.

Please use this checklist to help prepare for your child's visit.

☐ **Obtain a referral from your primary care physician.**
If you have not obtained a referral, you may need to reschedule your appointment until one can be obtained.

☐ **Complete the enclosed history forms and bring them to your appointment.**

☐ **Ensure our office has received all testing and/or medical records related to the reason for your referral.**

☐ **Bring a current list of your child's medications.**

☐ **Bring your insurance card and valid ID.**

☐ **Contact us regarding acceptance of your insurance.**
All insurance information from your primary care physician must be in our office prior to your visit or your appointment may need to be rescheduled. If you have questions regarding charges, our staff will be happy to discuss the charges for services provided to you. When your insurance plan changes, please call our office to verify that we are participants.

☐ **Bring legal proof of guardianship.**
- Foster parent needs TDPRS authorization forms.
- Grandparent needs written notice from legal parent.
- Step parent needs written notice from legal parent.

☐ **Arrive 30 minutes prior to your scheduled appointment.**
Allow adequate time for any needed paperwork and/or registration process. If you are late, your appointment may need to be rescheduled. Specialty care office visits and wait times may take up to two hours.

Appointment day:	Date:	Arrival time:

24-hour notice is required on all cancellations.
1500 Cooper St. - Dodson Specialty Clinics - Second Floor
Fort Worth, TX 76104

CookChildren's

billing information

For insurance purposes, the Gastroenterology and Nutrition Clinic is not a doctor's office visit. It is considered a "Hospital Outpatient" visit.

Please check your insurance benefits to ensure you are covered.

If you do not have insurance:

A deposit is requested for both physician and medical center charges prior to treatment. If you are not able to pay your bill in full, a referral to a financial counselor will be provided to you. You will receive separate bills for physicians' services, medical center charges and test/lab work.

If you have insurance:

You may be subject to a copay. If so, it will be applied to the respective bill. Your insurance may apply all or part of your medical center charges to your deductible. If you have not met your deductible, you may have a balance due at the time of your visit. Your insurance provider will receive separate invoices for physician's services, hospital charges and test/lab work.

I have read, understand and agree with the above financial policy. I understand that charges not covered by my insurance, as well as applicable copayments and deductibles are my responsibility.

I authorize my insurance benefits be paid directly to Cook Children's Gastroenterology and Nutrition Clinic.

I authorize Cook Children's Gastroenterology and Nutrition Clinic to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Printed Name Signature Date

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patient registration

Patient's name: Social Security #:

Date of birth: Sex: M / F Race (optional):

Mailing address:

City: State: Zip:

Home phone: Work phone: Cell phone:

Primary physician: Referring physician:

Parent or legal guardian information

Name: Relationship:

Mailing address (if different from patient):

Home phone: Work phone: Cell phone:

Date of birth: Social Security #: Employer:

Name: Relationship:

Mailing address (if different from patient):

Home phone: Work phone: Cell phone:

Date of birth: Social Security #: Employer:

CookChildren's℠

patient registration

Emergency contact

Name:	Relationship to patient:	Phone:

Insurance information

Primary insurance:	ID #:	
Claim address:	Claim phone:	
Insured:	Date of birth:	Relationship:
Employer name:	Phone:	

Secondary insurance:	ID #:	
Claim address:	Claim phone:	
Insured:	Date of birth:	Relationship:
Employer name:	Phone:	

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new patient history form

Patient name:________________________________ **Date of birth:**_____________________________

Why were you referred to a gastroenterologist? ____

What problem is your doctor most concerned about? ____

What problem are you most concerned about? ____

Prenatal/newborn history (Please circle response where appropriate)

Did you receive prenatal care during your pregnancy? Yes / No

Did you have any problems during your pregnancy? Yes / No

Was your delivery: Vaginal / C-section

List any problems you had during your pregnancy: ____

Was your baby born early? Yes / No If so, how early? _______ Name of birth hospital: _______________

Number of days in the newborn nursery: ______ Number of days in the Neonatal Intensive Care Unit: _____

Was your baby on a breathing machine? Yes / No How long? ______________________________________

Was your baby on a heart monitor? Yes / No Has it been discontinued? Yes / No

Please list any chronic medical problems: ____

Patient diet history

Infant: (Please circle response) Breast-fed / Formula-fed Is your infant on solid food? ______________

Older child: Please note any dietary restrictions: ____

Patient social history

Who does your child primarily live with? ____

Patient hospitalizations

Please list your child's hospitalizations, dates and reason for admission: ___________________________

____

____

Patient surgeries

Please list your child's surgeries, dates and reason for surgery:___________________________________

____

____

Patient injuries

Please list any serious injuries or accidents including age at the time of accident:___________________

____

medication list

Please list all medications your child is currently taking:

Medications including over the counter and herbal supplements	Dosage	Start date	Prescribing physician

Please follow medication instructions given by the prescribing physician.

Patient name:______________________________ **Date of birth:**____________________________

Allergies: ____

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patient developmental history

Please list any delays in your child's physical, mental or intellectual development: __________

____

Patient history of sexual activity, alcohol, tobacco or drug use

Does your child drink alcohol? Yes / No How many drinks per week? ____________________________

Does your child have any history of illegal drug use? Yes / No If so, what kind of drugs? _____________

Does you child use tobacco? Yes / No How often? ____

Is your child sexually active? Yes / No Has your child started her period? Yes / No When?___________

Patient review of systems

Please check "Y" for yes if your child has experienced any of the following within the last 3 months:

Y	Neurological Symptoms:	Y	Cardiac Symptoms:	Y	Urinary:
	Seizures		Chest pain		Bed-wetting
	Headaches		Irregular heartbeat		Loss of bladder control
	Double vision		Heart murmur		Excessive urination
	Dizziness		Fainting		Painful urination
	Numbness				Blood in urine
	Tingling	Y	Skin:		
	Loss of bowel/bladder control		Rashes	Y	Musculoskeletal:
			Change in skin color		Pain in arms/legs
Y	Respiratory Symptoms:		Bruise easily		Swelling in arms/legs
	Apnea				Pain in joints
	Cough	Y	Gastrointestinal:		Weakness
	Difficulty breathing		Vomiting		
	Wheezing		Diarrhea	Y	Psychiatric:
	Multiple upper respiratory infections		Foul breath		Depression
			Stomach pain > 3 months		Anxiety
Y	Ears, Eyes, Nose, Throat:		Constipation		Bipolar disorder
	Multiple ear infections		Stool accidents		Confusion
	Visual disturbances		Blood and/or mucous in stools		
	Nose bleeds		Painful bowel movements	Y	General:
	Difficulty swallowing food		Clay-colored stools		Frequent fevers
	Sores in mouth		Weight loss		Excessive fatigue
			Loss of appetite		

Patient name:________________________________ **Date of birth:**_____________________________

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family history

Please check any of the following that apply to biological parents, siblings and/or grandparents.

✓	Disease	Family member affected
	Asthma/emphysema/cystic fibrosis	
	Congenital heart disease/rheumatic fever/heart murmur	
	Heart attacks/hypertension	
	Sudden infant death syndrome/seizures	
	Diabetes/thyroid problems	
	Liver disease/hepatitis C	
	Crohn's disease/ulcerative colitis	
	Celiac disease/gluten intolerance	
	Stomach ulcer/gastritis	
	Irritable bowel syndrome/constipation/diarrhea	
	Hirschsprung's disease	
	Colon cancer/polyps	
	Gastroesophageal reflux	
	Food allergies	
	Rare metabolic diseases	
	Reaction to anesthesia	

Please list any other conditions not listed above and the family member affected:

Patient name: ______________________ **Date of birth:** ______________________

Form completed by: ______________________ **Date:** ______________________

Relationship to patient: ______________________ **Date:** ______________________

Form translated by: ______________________ **Date:** ______________________

Form reviewed by: ______________________ **Date:** ______________________

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