AR TEXAS PEDIATRICS
Health is LIFE

Dr. Aseema Raoshan, MD

LOCATION: 1
SOUTHEAST PROF BLDG
11914 ASTORIA BLVD, SUITE 450
HOUSTON, TEXAS, 77089

LOCATION: 2
IMPERIAL MEDIAL CENTER
1111 HIGWAY 6 SOUTH SUITE 120
SUGARLAND TX 77478

Who may we thank for referring you? _____ Did Dr. Raoshan see your child in the hospital? _____
Have you arranged to have your child's Medical records sent here from another doctor?_____
_____

Child's Full Name: _____ Date of Birth: _____/_____/_____ Sex: M __F ___
Address where child lives: _____

Phone number where child lives: _____ Child's SS#: _____
Names of other Children:
_____ Date of Birth: _____
_____ _____Date of Birth: _____
_____ Date of Birth: _____

Father's Full Name: _____ Date of Birth: _____ Cell: _____
Father's Home Phone #: _____ Work Phone #: _____ SS#: _____
Father's Employer Name & Address: _____

Mother's Full Name: _____ Date of Birth: _____ Cell: _____
Mother's Home Phone #: _____ Work Phone #: _____ SS#: _____
Mother's Employer Name & Address: _____

The person legally responsible for payment of this account: _____
Address: _____Tel#:_____
Billing Address, if different from child's _____
Relationship to patient: _____
_____
EMERGENCY NUMBERs: (person NOT living with child)
Name: _____
Address: _____Tel#:_____
_____

PRIMARY INSURANCE CO: _____ Pharmacy: _____
Group#: _____
Insured's I.D.#: _____
Insurance Company Tel#: _____
Ins Co. Address: _____
Name Policy is listed under:_____ _____

I hereby consent to, and request the medical treatment be provided to my children in accordance with the plan of care established by the Physician. I authorize the release of any medical information necessary to process claims, and also authorize the payment of medical benefits to the Physician described herein. If no payment is received from the Insurance Company, I agree to pay the balance.

Signature: _____ Date: _____

********** PAYMENT FOR ALL SERVICES IS REQUIRED AT THE TIME OF SERVICE **********

TEXAS PEDIATRICS AR
Health is LIFE

Child Health History

Child's name:_____Date of birth:_____Age:_____

PREGNANCY & BIRTH

How was your child born? _____

Is this child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other:_____

Please indicate any medical problems during pregnancy ☐ None ☐ Specify _____

_____

Delivery by: ☐ Vaginal birth ☐ Caesarean If Caesarean, why? _____

Birth weight:_____Birth length:_____APGAR score 1min._____5 min. _____

Please indicate any medical problems during the baby's newborn period: If premature, how early?_

_____

Other problems:

_____

_____

NUTRITION & FEEDING

Was your child breastfed? ☐ No ☐ Yes If so, how long? _____

Has your child had any unusual feeding/dietary problems? ☐ No ☐ Yes If yes, specify: _____

Milk intake now: Type ☐ Cow's milk (☐ Nonfat ☐ 1%fat ☐ 2%fat ☐ Whole milk ☐ Soy milk ☐ Rice milk

Average ounces per day (Note: 8 ounces = 1 cup) _____

SLEEP

Hours per night_____Naps (number & length) _____

Any sleep problems? _____

DENTAL HISTORY

Has child been seen by a dentist? ☐ No ☐ Yes If so, how often?_____Date of last visit_____

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Has your child had: ☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis

EXPOSURE/HABITS

Any Concerns about lead exposure? (old home/plumbing/peeling paint) ☐ No ☐ Yes

Has your child ever been exposed to anyone with tuberculosis? ☐ No ☐ Yes

Do any household members smoke? ☐ No ☐ Yes

TV Hours per day _____ Computer-hours per day _____ Video games- hours per day _____

TEXAS PEDIATRICS AR
Health is LIFE

Child Health History

SOCIAL HISTORY

Who lives at home?

Name Age Relationship

_____

_____

_____

Are there guns in the home ☐ Yes, ☐ No

Are your child's parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced If divorced, when? _____

Parent's occupation: Mother _____ Father _____

Child care situation: Parents _____ others (who and hours per day) _____

SCHOOL HISTORY

Did/does your child attend school or preschool? ☐ No ☐ Yes Elem/Middle/High _____
Circle one School name

Current Grade _____ School Performance _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates:

_____

_____

_____

Hospitalizations/Operations (with dates): _____

_____

Broken bones or severe sprains _____

FAMILY HISTORY

Please indicate family members (parents, siblings, grandparents, aunts or uncles) with any of the following conditions:

Alcoholism/Drug abuse_____ Heart disease _____ High Cholesterol _____
High blood pressure_____ Diabetes_____ Stroke_____
Depression_____ Bleeding/clotting problems_____ Cancer, specify type_____
Asthma/hayfever/eczema_____ Other_____

Parent/Guardian
Signature:_____Date: _____

Dr. ASEEMA RAOSHAN, M.D
11914 ASTORIA BLVD # 450, HOUSTON, TEXAS, 77089
1111 Highway 6S, Suite 120, Sugar land, Texas, 77478

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

PATIENT NAME: _____, Patient DOB: _____
Please Print

In the event you must be contacted by phone with regards to test results, referrals or other medical information, please let us know how you prefer this to be done by marking one or all of the following that may apply:

_____ **Leave message on machine at home.**

_____ **Leave message with** _____ **at** _____
Name Telephone Number

_____ **Contact me at my work telephone number** _____
Telephone Number

_____ **You may discuss any of my medical information with the following emergency contacts:**

_____ **at** _____
Name **Telephone Number**

_____ **at** _____
Name **Telephone Number**

---------- ---------- ----------
Signature Date Date of Birth