

NEW BRAUNFELS PEDIATRIC ASSOCIATES, P.A.

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Thank you for choosing our office. In order to service you properly, we will need the following information.

| PERSONAL DATA | | | | | |
|---|---|----------------------------------|-----------------------|---------------------|----------------|
| Mother's Name | | Age | Date of Birth | | |
| Home Phone # | | Cell Phone # | Social Security # | | |
| Emergency Contact Name & Relationship | | | Emergency Phone # | | |
| Mother's Address | | City | State | Zip Code | |
| Mother's Occupation | | Mother's Employer | | Employer Phone # | |
| Father's Name (or legally responsible adult) | | Home Phone # | | Cell Phone # | |
| Date of Birth | | Social Security # | | | |
| Father's Address | | City | State | Zip Code | |
| Father's Occupation | | Father's Employer | | Employer Phone # | |
| INSURANCE INFORMATION | | | | | |
| * Insurance companies may require you to add child within 30 days of birth for coverage * | | | | | |
| Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Name of Policy Holder | | Date of Birth | Policy Holder Address | City | State Zip Code |
| Name of Insurance Company | | Insurance Company Address | | City | State Zip Code |
| Group # | | Policy # | Co-pay Amount | | |
| Name of Policy Holder (Secondary) | | Date of Birth | Policy Holder Address | City | State Zip Code |
| Name of Insurance Company (Secondary) | | Insurance Company Address | | City | State Zip Code |
| Group # | | Policy # | Co-pay Amount | | |
| Are childhood vaccinations covered by your insurance plane? <input type="checkbox"/> Yes <input type="checkbox"/> No (If unknown, please determine) | | | | | |
| Referred By: | | | | | |
| Mother's OB/GYN Doctor: | | | | | |
| FAMILY HISTORY | | | | | |
| HAS ANY BLOOD RELATIVE EVER HAD | | FAMILY MEMBERS | | BIRTHDATE | HEALTH |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Excessive Bleeding | Father | | | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | Mother | | | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Trouble | Children | | | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid Trouble | | | | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Trouble | | | | |
| <input type="checkbox"/> Birth Defects | | | | | |
| PRENATAL DATA | | | | | |
| Mother's Due Date | | Medicines Taken During Pregnancy | | | |
| Number of Previous Pregnancies | | Miscarriages | Mother's Blood Type | Father's Blood Type | |