



**Anshu Dalela, MD**

Child 1:Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Sex:** M / F **Gestational age at birth:** \_\_\_\_\_ weeks \_\_\_\_\_ days

**Preferred Language:** \_\_\_\_\_

**Ethnicity (Circle One):**      Hispanic/Latino      Non-Hispanic/Latino      Decline

Child 2: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Sex:** M / F **Gestational age at birth:** \_\_\_\_\_ weeks \_\_\_\_\_ days

**Preferred Language:** \_\_\_\_\_

**Ethnicity (Circle One):**      Hispanic/Latino      Non-Hispanic/Latino      Decline

Child 3: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: M / F Gestational age at birth: \_\_\_\_\_ weeks \_\_\_\_\_ days

**Preferred Language:** \_\_\_\_\_

**Ethnicity (Circle One):**      Hispanic/Latino      Non-Hispanic/Latino      Decline

**Child 4: Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Sex:** M / F **Gestational age at birth:** \_\_\_\_\_ weeks \_\_\_\_\_ days

**Preferred Language:** \_\_\_\_\_

**Ethnicity (Circle One):**      Hispanic/Latino      Non-Hispanic/Latino      Decline

(If you have any more children let us know and we will get another front page)



Anshu Dalela, MD

**Primary Contact:** Child(ren)'s parents are (Circle One): Married   Divorced   Never Married   Separated  
Widow(er)   Other

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Best number to reach me (Circle One):** Work / Home / Cell

**May contact via (Circle One):** Work / Home / Cell / Email / Portal

**May leave messages/lab results via (Circle One):** Work / Home / Cell / Email / Portal

**May NOT leave messages/lab results via (Circle One):** Work / Home / Cell / Email / Portal

I would like to receive any **office updates** via text message:  **Send to cell**    **Do NOT send**

**Lives with patient(s)?**      Yes / No

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(Street)

(City/State/Zip)

**Secondary Contact:** Child(ren)'s parents are (Circle One): Married   Divorced   Never Married   Separated  
Widow(er)   Other

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Best number to reach me (Circle One):** Work / Home / Cell

**May contact via (Circle One):** Work / Home / Cell / Email / Portal

**May leave messages/lab results via (Circle One):** Work / Home / Cell / Email / Portal

**May NOT leave messages/lab results via (Circle One):** Work / Home / Cell / Email / Portal

I would like to receive any **office updates** via text message:  **Send to cell**    **Do NOT send**

**Lives with patient(s)?**      Yes / No

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(Street)

(City/State/Zip)

4909 Golden Triangle Blvd Suite 231 Fort Worth, Texas 76244 ☎ Phone (682)297-5437 ☎ Fax (682)228-6447 ☎  
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**Additional Contact Questions:**

Who should receive billing statements? \_\_\_\_\_

May all contacts have access to the patient's records? Yes / No

If parents are divorced, separated or unmarried, please fill out this section:

Who has custody? \_\_\_\_\_

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and **provide a copy of any legal paperwork** that supports this restriction. (We **must** have this on the patient(s) chart.)

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**Would you like to sign up for MyKid'sChart (patient portal)?**

Yes / No / Already Set Up:

If yes, please provide the best email: \_\_\_\_\_

**Emergency Contacts (other than parents)**

**Name & Relationship (leave blank if none):**

**Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_

**Pharmacy Phone Number and/or Pharmacy Address:** \_\_\_\_\_