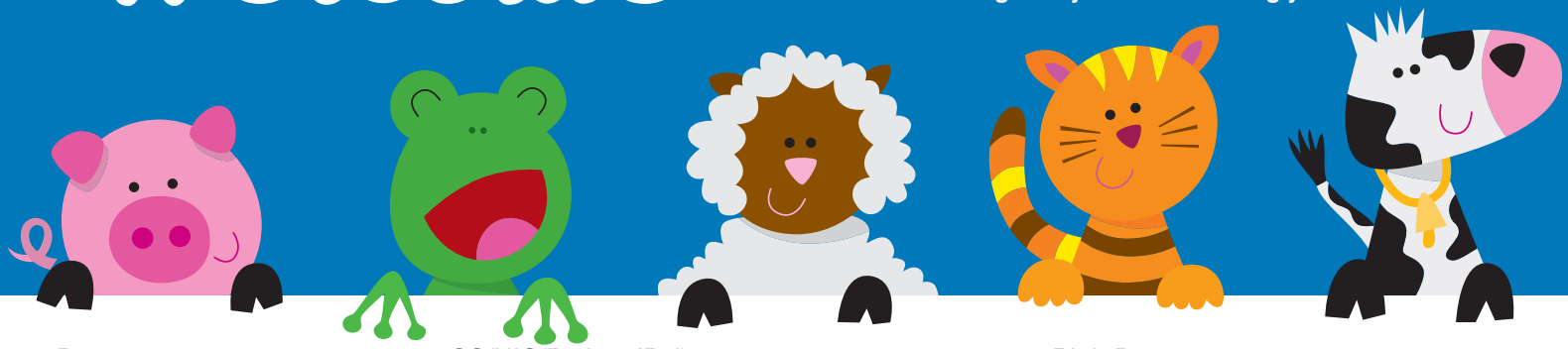
Welcome

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your child's health.



Patient Information

Date _____ SS/HIC/Patient ID #_____ Birth Date _____

Name of Minor/Child_____ Sex ❑ M ❑ F Age _____
Last Name First Name Middle Initial

Nick Name _____ Hobbies _____

Cell Phone (____)_____ Email Address _____

Home Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

School Name _____

Person Financially responsible_____ Home Phone (___)_____ Work Phone (____)_____

Whom may we thank for referring you? _____

Insurance

Father's/Guardian's Name _____

Address (if different from patient's_____

_____

Home Phone (___)_____ Work Phone (___)_____
(if different from above) (if different from above)

Email _____

Employer _____

Soc. Sec#_____ Birth Date _____

Plan Name _____ Phone (___)_____

Address _____

Group # _____ Policy #_____

Mother's/Guardian's Name _____

Address (if different from patient's_____

_____

Home Phone (___)_____ Work Phone (___)_____
(if different from above) (if different from above)

Email _____

Employer _____

Soc. Sec#_____ Birth Date _____

Plan Name _____ Phone (___)_____

Address _____

Group # _____ Policy #_____

Is your child eligible for treatment under Medical Assistance? ❑ Yes ❑ No Child's Medical Assistance I.D. #_____

Medical History

Minor/Child's Physician_____ City/State _____ Phone(___)_____

Date of last physical examination _____ Results _____

Is Minor/Child under care of physician now?.... ❑ Yes ❑ No

Receiving any medication or drugs?..... ❑ Yes ❑ No

Ever been hospitalized?..... ❑ Yes ❑ No

Ever had surgery?..... ❑ Yes ❑ No

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following? If yes, please (✓).

❑ A.I.D.S./H.I.V.	❑ Cancer	❑ Diabetes	❑ Measles	❑ Sinus Problems
❑ Anemia	❑ Cerebral Palsy	❑ Drug/Alcohol Abuse	❑ Mononucleosis	❑ Thyroid Disease
❑ Asthma	❑ Chicken Pox	❑ Kidney Disease	❑ Mumps	❑ Tuberculosis
❑ Bladder Problems	❑ Convulsions	❑ Liver Disease	❑ Rheumatic Fever	❑ Other

Birth History

Birth Trauma? ❑ Doctor Assisted ❑ Twisting and/or Pulling ❑ Vacuum Extraction ❑ Forceps

Newborn Trauma (medical procedures and test): ❑ Yes ❑ No
Does your child have any food allergies? ❑ Yes ❑ No
Has your child been immunized? ❑ Yes ❑ No
Reason for vaccination? ❑ Yes ❑ No
Did your child have any negative reaction to the vaccinations? ❑ Yes ❑ No
Has your child been on antibiotics? ❑ Yes ❑ No
Is your child currently taking any medications? ❑ Yes ❑ No
Is your child currently taking any vitamins? ❑ Yes ❑ No

Baby / Toddler (0-4)

Have any of the following occurred?

❑ Fall from a changing table
❑ Fall out of crib
❑ Tonsillitis
❑ Constipation
❑ (+ or -) weight gain
❑ Frequent crying spells
❑ Fall off of playground equipment
❑ Reaction to vaccines
❑ Sleeping problems
❑ Tumble down stairs
❑ Play in a Johnny Jumper
❑ Frequent fevers
❑ Repeated infections or colds
❑ Involvement in MVA
❑ Frequent ear infections
❑ Frequent diarrhea
❑ Colic
❑ Other (Please explain): _____

Child (5-12)

Have any of the following occurred?

❑ Fall from a tree
❑ Stomach pains
❑ Hyperactivity / Autism
❑ Leg / Knee pains
❑ Fall off of a bicycle
❑ Scoliosis
❑ Learning difficulties
❑ Sports accident
❑ Bed wetting
❑ Asthma
❑ Car accident
❑ Fall on playground
❑ Allergies
❑ Other (Please explain): _____

Emergency Contact

In the event of an emergency, whom should we contact?

Name_____ Relationship _____ Phone (_____) _____

Name_____ Relationship _____ Phone (_____) _____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the doctor to perform necessary services for the child named above, including but not limited to x-rays, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment play is completed or one year from the date signed below.

_____ _____ _____ _____
Signature of Parent, Guardian or Personal Representative | Date | Please print name of Parent, Guardian or Personal Representative | Relationship to Patient