WELCOME

The following information is needed in order to better serve you and your child. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT.

Name _____ **Date** _____

PATIENT INFORMATION

Address _____
City _____ State _____ Zip _____

Sex ☐ M ☐ F Birthdate _____ Age _____

Child's School _____

Mom's name _____
Birthdate _____ SS# _____
Employer _____
Occupation _____Years on Job _____

Dad's name _____
Birthdate _____ SS# _____
Employer _____
Occupation _____Years on Job _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____Work/Cell _____

Email _____
IN CASE OF EMERGENCY, CONTACT
Name _____Relationship _____
Home _____Work _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No
Date of accident _____

Type of Accident ☐ Auto ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Police Officer ☐ Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Current Health Concerns_____

Birth History: ☐Vaginal delivery ☐ C-section ☐ Forceps/vacuum extraction
☐ Easy ☐ Moderate ☐ Difficult

Does your child experience any of the following problems?

☐ frequent colds/flu	☐ ear infections	☐ sinus pain/allergies	☐ difficulty breathing	☐ asthma
☐ lethargic/fatigue	☐ headaches	☐ irritability	☐ hyperactivity	☐ learning disorder
☐ bed wetting	☐ acne/rashes	☐ eating disorder	☐ constipation	☐ diarrhea
☐ sleeping problems	☐ scoliosis	☐ menstrual problems	☐ stomach/digestive problems	

How does this affect your child's life?
☐ Difficulty performing daily activities.
☐ Excessive appetite or thirst.
☐ Hinders ability to play sports or activities.
☐ Poor posture when reading or watching TV.

Is your child accident-prone? Y/N
Has your child had any falls down stairs? Y/N
Has your child ever been hospitalized or had surgery? Y/N
Has your child ever been in an auto accident? Y/N
Has your child ever had a broken bone or sprain? Y/N

INSURANCE INFORMATION

How will your payment be made: ☐ Cash ☐ Check ☐ Visa/MC
Insurance Co. _____ Policy/Group # _____
Insured _____ Relationship to Patient _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself, and that I am responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care for any reason, any fee for professional services rendered me will be immediately due and payable.

Parent/Guardian Signature _____ Date _____

Note: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor. Thank You.