ALL HEALTH CHIROPRACTIC CENTER PEDIATRIC WELCOME FORM

Today's Date _____

Personal Information

Child's Full Name _____ Sex: M/F

Mother's Full Name_____ Father's Full Name _____

Street Address _____City _____ State ____ Zip _____

Home Phone No. ( ) _____-_____ Alternative Phone No. ( ) _____-_____

Birth date _____/_____/_____ Age _____ No. of Siblings _____

Birth Weight_____ Current Weight_____

Birth Length _____ Current Length _____

Insurance and Payment Information

Primary Insurance

Insurance Company Name _____Phone No. ( )_____ - _____

Subscriber/Insured's Name _____Relationship to Patient _____

Subscriber/Insured's Date of Birth __/___/____

Authorization and Assignment

I do hereby authorize payments of medical benefits to be made directly All Health Chiropractic Center, for services rendered to me. I also authorize All Health Chiropractic Center to release any medical information necessary to aid in the processing of my claims.

Authorized Signature _____

All first visit charges are payable when services are rendered.

Method of Payment to be used today? Cash Check Credit Card

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that All Health Chiropractic Center will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to All Health Chiropractic Center will be credited to my account upon receipt. However I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable.

Patient Signature _____ Date _____

Guardian's Signature Authorizing Care for Minor _____ Date _____

History

Type of Birth: Normal Vaginal_____ Forceps_____ Breech_____ Cesarean_____ Home_____

Birthing Center:_____ Hospital:_____

Provider who assisted Delivery: OB/GYN_____ Midwife_____ Doula_____Husband_____

Obstetrician/Midwife:_____

Problems During Pregnancy: _____

Pregnancy History: _____

_____

Delivery/Birth History: _____

_____

Problems During Labor/Deliver: _____

_____

Infant Feeding: Breast_____ Bottle_____ Formula_____

No. of Hours Sleep per Night:_____ Quality of Sleep: Good_____ Fair_____ Poor_____

Immunized: Yes No

Pediatrician: _____

Date of Last Visit to MD: _____/_____/_____ Purpose: _____

Childhood Diseases: Chickenpox _____ Rubella _____ Mumps _____ Rubeola _____Measles _____

Whooping Cough _____ Other _____

Surgeries _____ Medications _____

Accidents _____ Traumas (MVA's, falls) _____

Has This Child Ever Suffered From?

□ Dizziness □ Backaches □ Heart Trouble □ Chronic Earaches □ Diabetes

□ Hypertension □ Colds/Flu □ Arthritis □ Headaches □ Asthma

□ Neuritis □ Digestive Disorders □ Sinus Trouble □ Constipation □ Anemia

□ Orthopedic Problems □ Diarrhea □ Poor Appetite □ Hyperactivity □ Sugar Concentration

□ Behavioral Problems □ Bed Wetting □ Convulsions □ Paralysis □ Muscle Jerking

□ Fainting □ Walking Problems □ Broken Bones □ Ruptures/Hernias □ Neck Problems

□ Arm Problems □ Leg Problems □ Growing Pains □ Joint Problems □ Blood Disorders

□ Stomach Aches □ Tuberculosis □ Allergies □ Rheumatic Fever □ Other