

GRAY CHIROPRACTIC HEALTH CLINIC

PEDIATRIC PATIENT REGISTRATION

CONTACT INFORMATION:

Child's Name: _____ Child's Social Security: _____ - _____ - _____
last first middle

Mother's Name: _____ Father's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mother's Work/Cell Phone: _____ Father's Work/Cell Phone: _____

Fathers Email: _____ Mothers Email: _____

Obstetrician/Midwife: _____
Name Location and Phone #

Pediatrician/Family MD: _____
Name Location and Phone # Date of Last Visit

INSURANCE INFORMATION:

Primary

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co: _____

ID Number: _____

Group #: _____

Secondary (if applicable)

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co: _____

ID Number: _____

Group #: _____

ASSIGNMENT & RELEASE – PLEASE NOTE: YOU MUST SIGN BELOW EVEN IF YOU DO NOT HAVE INSURANCE

I, the undersigned certify that my dependant has insurance coverage with _____ and assign directly to Dr. Jennifer Waldroup Gray DC 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 for by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship to Patient

____/____/____
Date

AUTHORIZATION FOR CARE OF A MINOR

Chiropractic examination and therapeutic procedures including but not limited to spinal adjustments, ultrasound, heat/ ice application, electrotherapy, and manual muscle therapy are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

I HEREBY AUTHORIZE GRAY CHIROPRACTIC HEALTH CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY FOR MY CHILD/WARD.

PARENT / GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT

____/____/____
DATE

GRAY CHIROPRACTIC HEALTH CLINIC

PEDIATRIC PATIENT CASE HISTORY

Patient's Name: _____ Date of Birth: ____/____/____ Gender: M F

Reason for this visit: _____

Age: _____ Birth Weight: _____ Current Weight: _____ Birth Length: _____ Current Length: _____ # of Siblings: _____

Childs Congenital Anomalies/Defects: _____

Family History of Congenital Anomalies/Defects: _____

Type of Birth (circle all that apply): Normal Vaginal Forceps Breech Cesarean

Birthing Location: Home Birth Birthing Center: _____ Hospital: _____

Pregnancy History / Problems During Pregnancy: _____

Delivery & Birth History / Problems During Labor & Delivery: _____

APGAR Scores: ____ Was there presence at birth of: ____ Jaundice (yellow) ____ Cyanosis (blue)

Infant Feeding: Breast: ____ # of Months: _____ Bottle: ____ # of Months: _____

Formula: ____ # of Months: _____ Brand(s): _____

Number Of Hours of Sleep Per Night: _____ Quality of Sleep (circle): Good Fair Poor

Immunization History: _____

Developmental History - At what age did the child:

Childhood Diseases (check all that apply):

- Developmental milestones and childhood diseases checklist including: Respond to sound, Sit unaided, Chicken Pox, Mumps, Follow an object with his/her eyes, Stand unaided, Measles, Rubella, Hold head up, Walk unaided, Rubeola, Whooping Cough, Crawl, and Other: _____

Has this child ever suffered from (check all that apply):

- Medical conditions checklist including: Dizziness, Bed wetting, Tuberculosis, Blood Disorders, Chronic earaches, Diabetes, Digestive Disorders, Headaches, Heart trouble, "Growing pains", Arthritis, Fainting, Hyperactivity, Hypertension, Allergies, Neuritis, Neck problems, Convulsions, Asthma, Constipation, Anemia, Joint problems, Rheumatic Fever, Sinus trouble, Diarrhea, Poor appetite, Backaches, Arm problems, Walking problems, Behavioral problems, Paralysis, Broken bones, Leg problems, Muscle jerking, Colds/Flu, Stomach Aches, Ruptures/Hernias, and Other: _____

Present History & Allergies: _____

Surgeries: _____ Accidents: _____ Medications: _____

Family History: _____