New Patient - Pediatric

Dr. Crystal's Chiropractic Care

419 N. Cody Rd., Le Claire, IA 52753 (563) 271-0226

Child's Name: _____ _____
First MI Last Nickname / Preferred Name

Child's: Date of Birth: _____/_____/_____ Gender: ▢ M ▢ F ▢ N Height: ____ft.____in. Weight: _____lbs.

Parent/Guardian Info: ▢ Parent Other relation: _____

Name: _____ Birth date: _____/_____/_____ Phone #: (_____)_____-_____

Address: _____
Street Apt. # City State Zip

Email: _____ May we contact you through text messages? ▢ Yes ▢ No

How long has it been since the child has received chiropractic care? _____

Previous Chiropractor's Name: _____ Phone #: (_____)_____-_____

How did you hear about us? ▢ Signs ▢ Phone book ▢ Ad ▢ Internet Referral: _____ Other: _____

What **primary concern** brings you into the office today? _____

Date this ailment began: _____/_____/_____ (If you don't know the exact date, please estimate)

Please **describe how** this ailment began: _____

Please describe any complications or conditions surrounding the child's birth: _____

_____

Please list all of the child's surgeries, traumas, serious illnesses and medications: _____

_____

_____

_____

Pediatrician Info: Name: _____ Phone #: (_____)_____-_____

Insurance Policyholder's relationship to the patient: ▢ Self ▢ Parent Other: _____

If patient is **not** the policyholder, please enter the policyholder's information: ▢ Same as Guardian

Name: _____ Birth date: _____/_____/_____ Phone #: (_____)_____-_____

Address: _____
Street Apt. # City State Zip

I have read and I agree to all of the policies and procedures set forth within the Patient Health Information; Authorizations, Assignment of Benefits and Consent to Treat; and Notice of Privacy Practices (Rev 7/1/2013).

_____

Guardian Signature **Date**