

Pediatric Entrance Form

Date _____

Name _____ Social Security # _____

Age _____ Date of Birth _____ Home Phone _____

Who referred you to Dr. Vanderslice? _____

What was your child's birth like? (length in time, breech, home birth, water birth...) _____

C-section? Y N Nerve Block? Y N was labor Induced? Y N Forceps/Vacuum used? Y N

47% OF ALL CHILDREN FALL ON THEIR HEAD BY THE AGE OF ONE AND THEY HAVE AT LEAST 200 MORE MAJOR FALLS BY THE AGE OF 5 YEARS OLD.

When was your child's most recent fall? _____ Please describe _____

Has patient been injured in any sports activities? Y N If so explain _____

Has patient been involved in a motor vehicle accident as a passenger? Y N

Please describe if any injuries and if treatment was given: _____

What operations has the patient had and for what reasons? _____

Serious illnesses? (w/dates): _____ Vaccinations? _____

Has the child ever been under chiropractic care? Y N if so date of last adjustment? _____

The reason for this visit? _____

PAYMENT IS EXPECTED AT TIME OF SERVICE

Name of person responsible for payment _____

Insured? Y N if so company's name _____

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself furthermore, I understand that this chiropractic office 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 this office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account however, I clearly understand and agree that all services rendered 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 _____

Parent or Guardian authorizing care _____ Date _____