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# pEDIATRIC New Patient REGISTRATION FORM

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| Today’s date: | PCP:  |
| PATIENT INFORMATION |
| **Patient’s name:** |  |
| Is this your legal name? | If not, what is your legal name? | Birth date: | Age: | Sex: |
|  |  |  |  |  |
| Street address: | Social Security no.: | Home phone no.: |
|  |  |  |
| P.O. box: | City: | State: | ZIP Code: |
|  |  |  |  |
| **PARENT INFORMATION** |
| Mother’s Name: | Date of Birth | Father’s Name: | Date of Birth |
|  |  |  |  |
| Marital Status: | ( ) Single ( ) Married ( ) Divorced ( ) Other | Marital Status | ( ) Single ( ) Married ( ) Divorced ( ) Other |
| INSURANCE INFORMATION |
| (Please give your insurance card to the receptionist.) |
| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: |
|  |  |  |  |
| Occupation: | Employer: | Employer address: | Employer phone no.: |
|  |  |  |  |
| Insurance: |  |  |
| Subscriber’s name: | Subscriber’s Birth Date.: | Subscriber ID | Group no.: |
|  |  |  |  |
| Patient’s relationship to subscriber: |  |
| Name of secondary insurance (if applicable): | Subscriber’s name: | Subscriber ID: | Group no.: |
|  |  |  |  |
| Patient’s relationship to subscriber: | Choose an item. |
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| IN CASE OF EMERGENCY |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Phone No.: |
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| Medical History |
| Diagnosis: |  |
| Is your child having difficulty rolling, sitting, or walking? |  |
| Does your child have difficulty with balance and coordination?  |  |
| Complications/Health problems during pregnancy (check all that apply):( ) Diabetes( ) Measles( ) Toxemia( ) Premature Labor( ) Strep( ) Respiratory( )Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Complications during labor/delivery (check all that apply):( ) Cesaren Section If yes, was it an emergency? ( )Yes ( )No( ) Forceps( ) Vacuum( )Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child’s Condition at/or immediately after birth (check all that apply):( ) Premature If yes, Gestational age:\_\_\_\_\_\_\_\_\_( ) Apgar’s( ) NICU( ) Ventilator If yes, for how long?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( ) Jaundice( ) Heart Problems( ) Poor suck( )Small for Gestational Age( ) Large for Gestational Age( ) Known Diagnosis (e.g. Down’s Syndrome) If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Does your child have a history of (check all that apply):( ) Measles( ) Mumps( ) Pneumonia( ) Chicken Pox( ) Bronchitis( ) BPD( ) Reflux( ) Allergies( ) Head Injuries( ) Tonsillitis( ) Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does your child have a history of asthma, hay fever, eczema, or rashes? | Yes Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | No |
| Is your child have any food allergies? | Yes Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | No |
| Is your child allergic to any incense, essential oils, scents, lotions, or candles? | Yes Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | No |
| If your child on a special diet? | Yes Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | No |
| Is this problem related to an accident or injury?  | Yes Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | No |
| Have you received Physical, Occupational, Chiropractic or Speech therapy before? If yes, when and where? | Yes Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | No |
| Are you currently receiving home treatment? | Yes Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | No |
| Please List any hospitalizations or surgeries: |
|  |
| Please Check any tests you have had related to this problem: |
| MRI |  | XRAY |  | CT Scan |  | OTHER |  |
| Please List any medications currently taking: |
|  |  |
|  |  |
|  |  |
|  |  |
| Please list any pertinent family medical history: |
|  |
| Developmental History |
| Please list the approximate age your child accomplished these milestones |
| Lift head while on tummy |  | Crawled |  |
| Rolled over |  | Stood alone |  |
| Sat without support |  | Walked alone |  |
| Dress/Undressed Self |  | Button/Zip clothes |  |
| Open Cup |  | Dry during the day |  |
| Gain bladder/bowel control |  | Dry at night |  |
| Education History |
| What School does your child attend? | Current Grade Level |
| How often does your child attend school? | Days per week\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours a day \_\_\_\_\_\_\_\_\_ |
| What are your child’s strengths in school? |  |
| What areas of school are most difficult for your child? |  |
|  |
| Any concerns you would like to share with us regarding your child? |  |
| What goal would you like your child to work on? |  |
| Do you have questions for us? |  |
| Any behavioral issues? |  |
| Are there any behavioral strategies being used? |  |
| Please explain why you want to have this evaluation done: |  |
| Is there anything else you would like us know about your child? |  |
| Consent to TreatI consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy. |
| Patient/Guardian Signature |  | **Date:** |  |
| Patient/Guardian Name (Print) |  |
| Financial Responsibility I agree to pay my rehabilitation therapy provider all amounts that are due and owing for services rendered by Provider which are not otherwise paid for by Medicare, a third party insurance plan, a third party payor, or other payor source on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by Provider including, without limitation, reasonable attorney’s fees. |
| Patient/Guardian Signature |  | **Date:** |  |
| Patient/Guardian Name (Print) |  |