# 

# 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.: | | | | |
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| P.O. box: | | | | | | | | | City: | | | | | | | | State: | | | ZIP Code: | | | | |
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| **PARENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| Mother’s Name: | | | | | | | | | | | Date of Birth | | | | | Father’s Name: | | | | | | | Date of Birth | |
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| 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.: | | | | |
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| 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: | | | | | | | | | | | | | |
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| Please list any pertinent family medical history: | | | | | | | | | | | | | |
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| 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 Treat  I 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) | | |  | | | | | | | | | | |