RAMER CHIROPRACTIC PEDIATRIC FORM

Today's date: _____ Full Name: _____

Preferred Name: _____ Date of Birth: _____ Phone: _____

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

Parents Names: _____ Contact Phone: _____

Pediatrician: _____ Phone: _____

Number of Siblings _____ email address (for newsletter): _____

Who may we thank for referring you to our office? _____

REASON FOR TODAY'S VISIT

Please answer all questions on behalf of your child if they are not old enough to fill out form on their own.

Is this visit the result of (please circle): auto injury wellness care other

What is/are the health condition(s) you are concerned with today?

*Major complaint? _____

*Onset? _____

Is this condition (please circle): getting worse constant comes and goes

Is this condition interfering with your (please circle): school sleep daily routine. **Have**

you had this or similar conditions in the past? _____

Have you been treated by a Medical Doctor for this condition? _____

If so, where? _____ **Results?** _____

Have you ever had Chiropractic Care before? _____

If so, whom? _____ **Results?** _____

INSURANCE INFORMATION

Do you plan on using Health Insurance (including Medicare)? _____

If yes, please provide the front desk with the most recent insurance card for us to make a copy.

DATE_____ **PATIENT NAME**_____ **GUARDIAN SIGNATURE**_____

HEALTH HISTORY

My child is on the following vaccine schedule (please circle): standard alternative none

Please explain any difficulties during pregnancy or labor: _____

The following occurred at delivery (please circle all that apply):

Anesthesia used	Breech Presentation	Emergency C-Section	Face Presentation
Fetal Distress	Forceps/Vacuum	Head presention	Induced labor
Intensive care	Meconium Staining	Planned C-Section	Vaginal Delivery

During Infancy my child:

Breast Fed _____ mos	Bottle Fed _____ mos	Cried if position was changed	Had Earaches
Fell from high or low	Had Feeding Difficulties	Arched Back or Neck	Had a Preferred Head position

My child has met all developmental milestones: _____
Please list any other serious medical condition(s): _____

_____

Allergies: _____
Previous Surgeries: _____
Past Serious Accidents: _____
Family Health History: _____
Does your child: Take supplements or vitamins? _____ Follow a special diet? _____
Carry a backpack? _____ Play Sports (which one(s))? _____
Watch TV (time)? _____ Play Computer/Video Games (time)? _____

PAYMENT INFORMATION

PLEASE NOTE: On your first visit, payment is due in full at the time of service, unless prior arrange-ments were made. We DO accept insurance assignment, but NOT until we are able to contact your insurance carrier directly to verify benefits. Payment you make today which is verified to be covered by insurance will be credited to your account, or reimbursed upon your request. Based on this, payment today will be: _____Cash _____Check _____ Visa/MasterCard

It is the policy of this office to keep on file a credit card number for your account. You will only be charged if you authorize in writing OR if your account is over 90 days past due or as cancellation fee

Card type: Visa MasterCard Card number: _____ CVC _____ Exp. _____
I authorize the doctor to evaluate and care for me as she deems appropriate. I understand and agree that all services rendered to me at this office are my financial responsibility and are charged directly to me. Even if submitted to insurance, ultimately I am personally responsible for payment.

Patient/Guardian Signature _____ Date _____