Binder Family Chiropractic LLC Pediatric Registration & History Form

Patient Name: _____ S.S. #: _____

Address: _____ City: _____

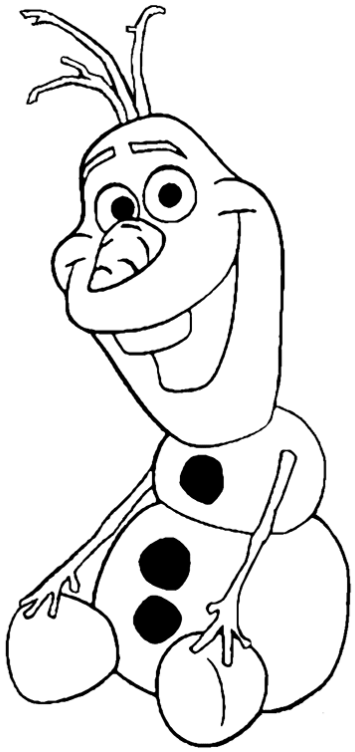
State: _____ Zip Code: _____ Home Phone #: (_____)_____

DOB: ____ / ____ / ____ Sex: _____ Weight: _____ Height: _____

Names of Parents / Guardians: _____

In Case of Emergency Contact: _____ Phone #: (_____)_____

Who should we thank for referring you? _____



INSURANCE

Who is responsible for this account? _____

Relationship to the patient: _____

Insurance Company: _____

Subscriber ID#: _____ Group #: _____

Is the patient covered by additional insurance?: Yes / No (circle one)

Subscriber's Name: _____

DOB: ____ / ____ / ____ SS#: _____

Employer: _____

Relationship to patient: _____

Insurance Company: _____

Subscriber ID #: _____

Group #: _____

Assignment & Release:

I, the undersigned, give authorization for care of the above named minor child. Additionally, I certify that I (or my dependent) have insurance coverage and assign directly to Binder Family Chiropractic LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use if this signature on all insurance submissions.

Responsible Party Signature: _____ Date: ____ / ____ / ____

PATIENT HISTORY

Previous Chiropractor: _____ Date of last visit: ____ / ____ / ____

Reason for visit: _____

Name of Pediatrician:_ _____ Date of last visit: ____ / ____ / ____

Reason for visit: _____

Number of doses of Antibiotics your child has taken:

During the past 6 months: _____

Total during his/her lifetime: _____

Vaccination History: _____

Circle any of the following conditions your child has or has suffered from:

Ear infections	Scoliosis	Chronic Colds	Headaches	Seizures	Colic	Asthma / Allergies
Digestive Problems	ADHD	Auto Accident	Recurring Fevers	Growing / Back Pain	Bed Wetting	Temper Tantrums

Other (please list)**:**

_____

PRENATAL HISTORY

Name of Obstetrician/Midwife: _____

Complications during pregnancy: Yes / No (circle one)

If yes, please list: _____

Ultrasounds during pregnancy: Yes / No (circle one) If yes, how many: _____

Medications during pregnancy/Delivery: Yes / No (circle one)

If yes, please list: _____

Cigarette/ Alcohol use during pregnancy: Yes / No (circle one)

Location of birth: Hospital / Birthing Center / Home (circle one) If other, please list: _____

Birth Intervention: Forceps / Vacuum Extraction / C-section (circle one)

If other, please list: _____

Complications during Delivery: Yes / No (circle one) If yes, please list: _____

Genetic disorders or disabilities: Yes / No (circle one) If yes, please list:_____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

FEEDING HISTORY

Breast Fed: Yes / No (circle one) If yes, how long: _____

Formula Fed: Yes / No (circle one) If yes, how long: _____

Introduced to solid foods at _____ months old.

Introduced to cow's milk at _____ months old.

Food/Juice Allergies or Intolerance: Yes / No (circle one) If yes, please list: _____

DEVELPOMENTAL HISTORY

During the first years of life your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to: (indicate below each box)

Respond to Sound	Respond to Visual Stimuli	Hold Head Up	Cross Crawl	Sit Up	Stand Alone	Walk Alone

According to National Safety Council, approximately 50% of children fall head first from a high place during their first year of lie (i.e. a bed, changing table, stairs etc.) Was this the case with your child? Yes / No (circle one)

Is/has your child been involved in any high impact or contact type sports: Yes / No (circle one)

If yes, please list: _____

Has your child ever been involved in an auto accident? Yes / No (circle one)

If yes, please list: _____

Has your child been seen on an emergency basis? Yes / No (circle one)

If yes, please list: _____

Has your child had any prior surgeries? Yes / No (circle one)

If yes, please list: _____

CHILDHOOD DISEASES

Has your child ever been diagnosed with any of the following:

Chicken Pox:	Yes	No	If yes, what age?
Mumps:	Yes	No	If yes, what age?
Rubella:	Yes	No	If yes, what age?
Rubeola:	Yes	No	If yes, what age?
Whooping Cough:	Yes	No	If yes, what age?