Confidential Pediatric Patient Information

Patient Name_____ **Date**_____

Birth Date _____

Sex: ❍Male ❍Female

Birth Weight_____ pounds

Current Weight_____ pounds

Birth Length_____

Current Length_____

Duration of Pregnancy _____ weeks

Parent's Name_____

Parent's Name_____

Number of Siblings_____

Address_____

_____

Home phone_____

Work Phone_____

Cell Phone_____

Email _____

Best place to reach you:

❍Home ❍Work ❍Cell

Birth History

Type of Birth: ❍Normal Vaginal ❍Forceps ❍Suction Extractor ❍Breech ❍Cesarean

❍Home ❍Birthing Center _____ ❍Hospital _____

Problems during pregnancy? _____

Problems during labor? _____

_____

Obstetrician/Midwife Name: _____ Location: _____

Apgar Score at Birth_____ Apgar Score at 5 Minutes_____

At birth was there presence of : ❍Jaundice ❍Cyanosis (bluing)

Congenital Anomalies/ Defects: _____

Feeding: ❍Breast ❍Bottle ❍Formula

Number of Sleeping Hours per Night_____ Rate Quality of Sleep: ❍Excellent ❍Fair ❍Poor

Pediatrician/ Family MD Name: _____ Location: _____

Date of last office visit to MD: _____ Purpose: _____

Immunizations and Reactions: _____

The reason for this appointment today? _____

_____

Please turn over for authorizations and billing details

Name_____ **Date**_____

Authorization for Care of a Minor

I authorize Dr. Gargan and/or Dr. Shannahan and whomever they may designate as there assistants to administer treatment and x-rays as needed to my child / dependent , _____ .

name of minor child

Parent/Guardian Signature_____

Billing Details

We strive to offer a service that is of high quality and affordable. Since we can't guarantee that all health insurance plans will cover your care here, payment is required at the time of service unless other arrangements have been made with our office manager. We will gladly file any applicable insurance for you. **Please give your insurance card or claim information to the person at the front desk for copying.**

1. How will you be handling your financial account?

❍ Cash ❍ Health Insurance ❍ Auto Insurance/ Personal Injury ❍ Labor & Industries ❍ Medicare

Authorization for Insurance Payment & To Release Medical Information

I authorize my insurance carrier(s) to make payment for the expense benefits allowed and otherwise payable to me, directly to Summit Family Chiropractic for professional services I have received while under Dr. Gargan's and/or Dr. Shannahan's care. I authorize the release of any medical information necessary to process my insurance claim(s). I have agreed to pay, in a current manner, any balance of said professional charges. I understand and agree that ultimately, I am responsible for the final settlement of my account.

Parent/Guardian Signature_____