ADVANCED HOLISTIC HEALTH CARE
901 Stewart Ave., Suite 285
Garden City, NY 11530
516.742.5715

Children's New Patient Information

Child's Name_____ Date of Birth_____ Age_____ SS#_____

Guardian _____Relationship to child_____ Phone # _____

Gender: M F Who referred you to our practice? _____

Patient's Insurance

Name of Company_____ ID#_____ Group#_____

Address_____ Phone#_____

Insured Name_____Insured SS#_____ Who is responsible for payment? _____

Address_____City_____State_____Zip_____

Additional Information

Name of Primary Doctor_____ Specialty_____ When were you last seen by the doctor above?_____

Please list any medications the child currently takes_____

Date of illness or onset?_____Time_____AM/PM Location_____ Related to accident?_____ Auto_____ Other _____

Please explain: _____

List any Doctors seen for this condition_____

List in order of importance-current symptoms or current activity restrictions:

1._____ Causes pain_____ Unable to perform _____

2._____ Causes pain_____ Unable to perform _____

3._____ Causes pain_____ Unable to perform _____

4._____ Causes pain_____ Unable to perform _____

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Please list any previous medical conditions including falls, accidents, colic, or surgeries:

_____

_____

Child information and release

Please check health complaints your child is currently experiencing on a reoccurring basis:

( ) Asthma ( ) Headache ( ) Ear infection ( ) Allergies ( ) Bed Wetting

Please check any childhood disease your child has had:

( ) Chicken Pox ( ) Measles ( ) Mumps ( ) Rubella ( ) Whooping Cough ( ) Ear Infection

Please comment on how often any of the above diseases have occurred and when they occurred:

_____

_____

Pregnancy normal? ( ) Yes ( ) No

Complications? _____

Delivery: ( ) Home ( ) Hospital

Complications? _____

Medications during delivery (if any): _____

Immunizations: (List those received and age)_____

_____

List any surgeries or congenital conditions:_____

_____

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*Informed Consent:

I do hereby authorize the Doctor of Advanced Holistic Healthcare to administer care that is necessary for my case. This may include consultation, examination, adjustments, or any other procedure, which is advisable and necessary for my healthcare. The doctors here provide a specialized, non-duplicating health care service which includes detecting and correcting spinal subluxations (a misalignment of one or more vertebrae causing a blockage in nerve flow). It is important to note that the doctor does not diagnose, treat, or cure disease. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated, however, it is the responsibility of the patient to make it known whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor.

Acknowledgement
I have been informed that upon request I can receive a copy of the privacy practices (HIPPA). I am aware that I have an opportunity to discuss my rights to privacy if I please.

Print Name: _____ **Signature:** _____ **Date:** _____

*Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Print Name: _____ Signature: _____ Date: _____

Communications:

In the event we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____ Children: _____ Others: _____