PARTNERS IN HOLISTIC HEALTH, Inc.

PEDIATRIC REGISTRATION FORM

(Please Print)

PATIENT INFORMATION				
Patient's LAST NAME:	FIRST:	MIDDLE:		
Street address:		SEX:	Home phone no.:	
		❑ M ❑ F	( )	
Birth Date	Age	City:	State:	ZIP Code:
/ /				
Who Spends the Most Time Caring for the Child		Occupation of Parents or Guardian:	Work phone no.:	
			( )	
Mothers Name		Address:		
Fathers Name		Address:		
List any Drug Allergies or Reactions to Medications:				
Patients' HEIGHT:		Patients' WEIGHT:		
HOW DID YOU HEAR ABOUT US:				
EMAIL ADDRESS:				

FINANCIAL RESPONSIBILITY & INSURANCE INFORMATION				
Person responsible for bill:				
NAME OF INSURANCE COMPANY:			Home phone no.:	
			( )	
Are you Covered by Insurance:	❑ **Yes**	❑ **No**	**Group #:**	
Policy #	**Co-payment**	**ID#**	Employer phone no.:	
			( )	
I WILL BE PAYING TODAY BY: **CASH** ❑ **CHECK** ❑ **CREDIT CARD** ❑				

Make Checks to: PARTNERS IN HOLISTIC HEALTH

GENERAL INFORMATION	
NAME AND AGES OF BROTHERS AND SISTERS	AGE
1)	
2)	
3)	

Has your Child been Hospitalized? ❑ Yes ❑ No **If Yes:** Recently? ❑ Yes ❑ No How Many Times? _____

***** PLEASE INCLUDE TYPE OF OPERATION OR ILLNESS & LOCATION OF HOSPITALISATION *****

HOSPITALISATION (1)	HOSPITALISATION (2)	HOSPITALISATION (3)

Do you have worrisome financial problems? : ❑ Yes ❑ No :	Do you have transportation problems getting here? : ❑ Yes ❑ No
IF YES PLEASE EXPLAIN:	

HEALTH QUESTIONNAIRE

IF THIS CHILD HAS EVER BEEN BOTHERED WITH ANY OF THESE PROBLEMS *CHECK YES*

YES NO

- ☐ ☐ Frequent or Severe Headaches
- ☐ ☐ Eye Irritation
- ☐ ☐ Eyes Crossing
- ☐ ☐ Trouble with Vision
- ☐ ☐ Wears Glasses
- ☐ ☐ Earaches or Running Ears
- ☐ ☐ Difficulty Hearing
- ☐ ☐ Pulling or Tugging his/her Ears
- ☐ ☐ Speech Impediment
- ☐ ☐ Dental Problems
- ☐ ☐ Sore or Bleeding Mouth or Gums
- ☐ ☐ Frequent Colds
- ☐ ☐ Mouth Breathing
- ☐ ☐ Recurring Nosebleeds
- ☐ ☐ Recent Sore Throat
- ☐ ☐ Hoarse Voice
- ☐ ☐ Wheezing or Gasping
- ☐ ☐ Coughing Spells
- ☐ ☐ Shortness of Breath while Walking or Playing
- ☐ ☐ Must Squat or Hunch Down often While Playing

YES NO

- ☐ ☐ Burping or Gas
- ☐ ☐ Abdominal Pain
- ☐ ☐ Vomiting
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Itching at Anus
- ☐ ☐ Blood With Stools
- ☐ ☐ Must have a Special Diet
- ☐ ☐ Pain or Crying when Urinating
- ☐ ☐ Brown, Black or Bloody Urine
- ☐ ☐ Bedwetting (Over 4 yrs Old)
- ☐ ☐ Daytime Wetting (Over 3 yrs Old)
- ☐ ☐ Discharge from Penis or Vagina
- ☐ ☐ Frequent Urination
- ☐ ☐ Chest Pains
- ☐ ☐ Marked Increase In Diet
- ☐ ☐ Marked Decrease in Diet
- ☐ ☐ Weight Loss or Gain
- ☐ ☐ Rash or Swellings After Eating Certain Food
- ☐ ☐ Hay Fever or Allergies in spring, to animals, ETC
- ☐ ☐ Skin Rashes or Swellings

Yes NO

- ☐ ☐ Itching Skin
- ☐ ☐ Warts
- ☐ ☐ Bruises or Bleeding Problems
- ☐ ☐ Accidental Poisoning
- ☐ ☐ Listless or Tired
- ☐ ☐ Recurrent Fevers
- ☐ ☐ Motion Sickness
- ☐ ☐ Serious Accidents, Sprains, Broken Bones
- ☐ ☐ Shyness
- ☐ ☐ Frequent Nightmares
- ☐ ☐ Waking Often During Night
- ☐ ☐ Fears
- ☐ ☐ Overly Clinging
- ☐ ☐ Easily Upset, Crying
- ☐ ☐ Temper Fits
- ☐ ☐ Breaks or Throws Things
- ☐ ☐ Fighting
- ☐ ☐ Stealing
- ☐ ☐ Lying
- ☐ ☐ Nervous or Nervous habits
- ☐ ☐ Special School or Classes
- ☐ ☐ Problems at School
- ☐ ☐ Problems with the Family

Additional Comments or Special Problems: _____

MEDICAL HISTORY

IF THIS CHILD HAS EVER BEEN BOTHERED WITH ANY OF THESE PROBLEMS CHECK YES

YES NO

- ☐ ☐ Asthma
- ☐ ☐ Blood Disorders (anemia, Etc.)
- ☐ ☐ Chicken Pox
- ☐ ☐ Convulsions or Fits
- ☐ ☐ Croup
- ☐ ☐ Eczema
- ☐ ☐ Frequent Bronchitis
- ☐ ☐ German Measles (3-day)
- ☐ ☐ Hospitalization or Operations
- ☐ ☐ Measles (10-Day)
- ☐ ☐ Mumps
- ☐ ☐ Pneumonia
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Scarlet Fever
- ☐ ☐ Whooping Cough
- ☐ ☐ Worms

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BIRTH HISTORY

Place of Birth _____
(HOME, NAME OF HOSPITAL) CITY STATE

Birth Weight _____

IF THE CHILDS MOTHER HAS ANY OF THESE PROBLEMS DURING HER PREGNANCY WITH THIS CHILD CHECK: YES

(IF UNSURE LEAVE BLANK)

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Gonorrhea or Syphilis	☐	☐	Was the Baby Born with Forceps, Cesarean, Bottom First? (Circle)
☐	☐	Diabetes or Sugar in Urine	☐	☐	Frequent Cigarettes			
☐	☐	Albumin or Protein in Urine	☐	☐	Was Prenatal Care Received before the 6th month of pregnancy	☐	☐	Did the Baby have any Problems at Birth or need Help to Start Breathing?
☐	☐	Urinary Infection						
☐	☐	German (3 day) measles	☐	☐	Was this Child Born Premature	☐	☐	Did the Baby remain in the Hospital longer than the Mother
☐	☐	Drug or Drinking Dependence	☐	☐	Was the Birth Difficult			
						☐	☐	Was this Baby Breastfed?
								Until What Age:_____?

Place an (X) in the appropriate column for any illnesses that this child's blood relatives have had!

	MOM	POP	Maternal Grandma	Maternal Grandpa	Sib	Sib	Sib	Paternal Grandma	Paternal Grandpa	ILLNESSES
1										Allergies
2										Anemia
3										Arthritis/Gout
4										Asthma
5										Bleeding/Bruising problems
6										Cancer or Tumors
7										Convulsion/Epilepsy
8										Diabetes
9										Digestive Conditions
10										Drinking or Drug Problems
11										Frequent Infections
12										Genetic Diseases
13										Headaches
14										Heart Disease
15										High Blood Pressure
16										Kidney Disease
17										Mental Illnesses
18										Pneumonia
19										Polio
20										Rheumatic Fever
21										Skin Conditions or Eczema
22										Stomach or Intestinal Disease
23										Thyroid Problems
24										Tuberculosis
25										Weight Problems
26										
27										
28										
29										
30										
31										

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		
ADDRESS:		
RELATIONSHIP:	Cell Phone no: ( )	Home Phone No: ( )

TESTS & IMMUNIZATIONS

Please Check the immunizations or Test this Child has had and if you can give the year that the Child last had them:

YES	YEAR	TEST	YES	YEAR	IMMUNIZATIONS
		CHEST X-RAY			HEPATITIS
		KIDNEY X-RAY (PYELOGRAM)			M.M.R.
		G.I. SERIES			MEASLES
		COLON X-RAY (BARIUM ENEMA)			MUMPS
		GALLBLADDER X-RAY (CHOLECYSTOGRAM			DPT (DIPTHERIA, PERTUSSIS, TETANUS)
		ELECTROCARDIOGRAM			POLIO
		T.B. TEST			TYPHOID
		OTHER X-RAYS			RUBELLA
		M.R.I.			BAD REACTION TO SHOTS
		ULTRASOUND			TETANUS
		C.A.T. SCAN			SMALL POX

HAS THIS CHILD HAD A BAD REACTION TO ANY SHOTS? ***YES:*** ***NO:***

Other Doctors or Therapists involved in your Child's care? (Please include phone number)

1)

2)

Any other concerns or comments about your Child's health and well being; Mentally, Emotionally or Physically:

POLICIES

THE FOLLOWING SERVICE SHARGES WILL BE ASSESSED:

	Missed Appointment Charge ----------Current Office Visit Charges.
	1.5% Interest Per Month on any past due balances
	$20 bounced check Charge
	Charges may also be made for appointments cancelled without 24 hours advance notice.

Your health care is being provided by Partners in Holistic Health, Inc., an Arizona Corporation. By signing below, you agree that in the event of any claim that you may have relating to your health care, your claim is against the corporation and not against individuals who are shareholders and/or employees of the corporation.

We must emphasize that as your health care provider, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on pages 1 and 2 and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

SIGNATURE

The above information is true to the best of my knowledge. I understand I am financially responsible for any balance			
Patient/Guardian signature		*Date:*	