

**Pediatric Patient Entrance Information**

Please complete this form and then return to the receptionist.

***PLEASE PRINT*** Today’s Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Child’s Name: (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Middle)\_\_\_\_\_\_\_\_

Birth date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Apt. #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Phone: Home/Cell: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_Work: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_

Parents Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we add you to our email newsletter and calendar of events? ❑ Yes ❑ No (Your email will not be shared)

***Referral Information***

How did you find out about Sherman College Health Center?

❑ Advertisement ❑ Current Employee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Live Nearby ❑ Providence / Collaborative Team Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Spinal Screening ❑ Other Health Care Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Newsletter ❑ Current / Former Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Facebook ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***In Case of Emergency***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_)

***Childs Parent/Guardian Current Employer & Address:***

Name:

Address:

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Health Care Professionals:***

**(Chiropractor, Family Doctor, Specialist, Naturopath, Homeopath, etc)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Professional Designation: ❑ DC ❑ MD ❑ other \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_

Date and Reason for visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spinal X-rays taken: Y N Date; \_\_\_/\_\_\_\_/\_\_\_\_\_ Reason for care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Childs Height: \_\_\_\_\_ ft. \_\_\_\_\_\_ in. Weight: \_\_\_\_\_\_\_\_\_ lbs. Native Language:

Race: ❑ White ❑ Black ❑ Hispanic ❑ Asian ❑ Other

**Why are you seeking chiropractic care for your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this your child’s Major Health Concern?** ❑ Yes ❑ No **If not, what is?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

When did it start? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ It started: ❑ Suddenly ❑ Came on gradually

Duration of problem / episode: ❑ \_\_\_\_\_Minute(s) ❑ \_\_\_\_\_Hour(s) ❑ \_\_\_\_\_Day(s) ❑ \_\_\_\_\_Week(s)

Does this condition interfere with your child’s: ❑ Sleep ❑ Daily activity ❑ Mood ❑ Feeding

What do you think brought on your child’s condition?

What makes it better?

What makes it worse?

**Describe Your Child’s Condition:**

❑ Constant ❑ Comes and Goes ❑ Intense ❑ Mild ❑ Localized

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does Your Child Have Difficulty?**

❑ Sitting ❑ Standing ❑ Bending ❑ Walking ❑ Reaching ❑ Turning

Is this related to an auto accident? ❑ No ❑ Yes

Are you in litigation for any accidents? ❑ No ❑ Yes

Are you related to a student at Sherman College? ❑ No ❑ Yes If Yes: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Birth Experience***

Location of Birth: ❑ Home ❑ Hospital ❑ Birthing Center ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications used during labor / delivery: ❑ No ❑ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was Pitocin used to induce labor: ❑ No ❑ Yes

Was delivery vaginal? ❑ No ❑ Yes or C-section? ❑ No ❑ Yes

If delivery was vaginal, how was the baby presented? ❑ Head ❑ Face ❑ Breech

Were any interventions used to assist delivery? ❑ Forceps ❑ Vacuum Extraction ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any complications (emotional stress, MVA, falls, drugs) during pregnancy? ❑ No ❑ Yes

If Yes, Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any complications during delivery? ❑ No ❑ Yes Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of labor from first contraction to birth? \_\_\_\_\_\_\_Hours \_\_\_\_\_\_Minutes

Length of pushing stage? \_\_\_\_\_\_\_\_Hours

How many weeks of gestation was the baby at birth? \_\_\_\_\_ weeks

Baby’s birth weight? \_\_\_\_\_lbs \_\_\_\_\_ozs. Babys birth length? \_\_\_\_\_inches

Was the baby admitted to the Neonatal Intensive Care? ❑ No ❑ Yes If yes, for what and how long? \_\_\_\_\_\_

Was the baby given any medication at birth? ❑ No ❑ Yes If yes, what medications and why?\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Child’s Health History***

Does your child have a favorite sleeping position? ❑ No ❑ Yes If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Childs Hours of sleep per night? \_\_\_\_\_ Quality of sleep? ❑ Good ❑ Fair ❑ Poor

Other sleep patterns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any difficulties feeding? ❑ No ❑ Yes If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently breast feeding? ❑ No ❑ Yes If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Formula feeding? ❑ No ❑ Yes If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the baby prefer one breast over the other? ❑ No ❑ Yes If yes, which side? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your baby frequently arch their back and neck backwards? ❑ No ❑ Yes if yes, how often? \_\_\_\_\_\_\_\_\_\_

Does your baby appear sensitive to any foods in your diet or their own? ❑ No ❑ Yes If yes, what foods?

Tell us what your child eats during a normal day. Breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dinner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child gassy/colicky? ❑ No ❑ Yes If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child meeting their major milestones? ❑ No ❑ Yes If no, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child exposed to second hand smoke? ❑ No ❑ Yes If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any known allergies? ❑ No ❑ Yes If yes, to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child vaccinated? ❑ No ❑ Yes, following schedule. ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is/has your child on any medications including antibiotics? ❑ No ❑ Yes. If yes, list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Child’s Trauma History***

Has your child ever been involved in a motor vehicle accident? ❑ No ❑ Yes If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever fallen from a high place? ❑ No ❑ Yes If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child broken any bones? ❑ No ❑ Yes. If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been hospitalized other than at birth? ❑ No ❑ Yes If yes, why and for how long \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever undergone any surgeries? ❑ No ❑ Yes If yes, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Child’s Family History***

❑ No ❑ Yes Diabetes, Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No ❑ Yes Thyroid disease, Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No ❑ Yes Tuberculosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No ❑ Yes Kidney disease, Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No ❑ Yes High blood pressure, high cholesterol, triglycerides \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No ❑ Yes Heart Attack, other heart disease: Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No ❑ Yes Musculoskeletal disease, Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No ❑ Yes Cancer, Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No ❑ Yes Stroke, aneurysm, blood clot, deep vein thrombosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No ❑ Yes Osteoporosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No ❑ Yes Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Goals for Your Child***

What benefit(s) do you hope to gain for your child from regular chiropractic care?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Consent to Chiropractic Care for Child***

Chiropractic care is based on clinical evidence of vertebral subluxations and not the presence or absence of pain, abnormal range of motion, or abnormal spinal curves. By the use of specific analysis and specific spinal adjustments, the goal of chiropractic is the correction of vertebral subluxations. X-rays taken are for the purpose of determining a chiropractic x-ray analysis, and to help determine if there may be any contraindications to chiropractic care.

* I understand that my record and/or x-rays are the property of Fully Known Chiropractic and will be used for teaching and research purposes and if at any time I request a copy of my record and/or x-rays there will be an additional charge for copying them.
* I authorize Fully Known Chiropractic and its agents to administer care as needed, as indicated from examination findings
* I authorize Fully Known Chiropractic to release information to any other health care provider I am seeing and / or insurance company.
* I understand that if I am in litigation for any accident my settlement may be jeopardized by the fact that a student is rendering my care.
* A parent MUST accompany his/her infant child on all visits to Fully Known Chiropractic.
* I hereby authorize and grant permission for my child to receive regular chiropractic examination/evaluation including health history, spinal scan, examination, x-rays if warranted, and specific chiropractic adjustments as needed.

***I have reviewed and certify that all of the information that I have reported above is true to the best of my knowledge and that I have read and understand the “Consent to Chiropractic Care for Child” above.***

Custodial Parent/Guardian Signature: Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Relationship to patient:

Witnessed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Faculty DC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Office Use: Patient Type: ❑OP ❑PB ❑Prov ❑CTM ❑Medicare ❑BCBS ❑Returning Patient**

**❑Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Entered: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ By \_\_