

DR # _____

CASE # _____

The MANTONYA CHIROPRACTIC CENTERS Est. 1971
PEDIATRIC PATIENT INTRODUCTION FORM

(Please Print)

Child's Name _____ **Date** _____
First Middle Last

Address _____ **PO BOX** _____

City _____ **State** _____ **Zip** _____ **Phone-Area Code**() _____

SS# _____ **Birth Date** _____ ()Male ()Female **Age** _____ **Height** _____ **Weight** _____

Parent's Name _____ **Occupation** _____

Business Phone() _____ **Name Of Partner/Spouse** _____

Spouse's Occupation _____

REFERRED BY _____

If you were referred by a telephone directory, please indicate which one was used: **ALLTEL **OTHER**

A) Child's Main Complaint(s):

- ____ Colic
- ____ Ear Infections
- ____ Colds
- ____ Headaches
- ____ Back Pain
- ____ Seizures
- ____ Arm Pain
- ____ Leg Pain
- ____ Vomiting
- ____ Attention Deficit
- ____ Fatigue
- ____ Bed Wetting
- ____ Asthma
- ____ Diarrhea
- ____ Constipation
- ____ Allergies
- ____ Nose Bleeds
- ____ Lazy Eye
- ____ Other: _____

(B) Child's Birth:

- ____ Normal Vaginal
- ____ Complicated Birth
- ____ C-Section
- ____ Forceps
- ____ Suction

(C) Has Your Child:

- ____ Played Sports
- ____ Been Knocked Unconscious
- ____ Been in an Auto Accident
- ____ Fallen
- ____ Broken Any Bones

(D) Recent Injuries: _____

- _____
- _____

(E) Any prescription or non-prescription medication your child is taking: _____

- _____
- _____

(F) Their Pediatrician:

- _____
- _____

(G) Has your child seen a Chiropractor before:

____ YES ____ NO

If So:
Who? _____
When? _____

Do You Have Health Insurance? (Circle One) YES NO

Primary Insurance Company Name _____

Secondary Insurance Company Name _____

PARENT/GUARDIAN SIGNATURE: _____

FEES PAYABLE AT TIME OF SERVICE UNLESS ARRANGMENTS ARE MADE

The MANTONYA CHIROPRACTIC CENTERS

Improving Lives with Expert Healthcare since 1971.

919 North 21st St.
Newark, OH 43055
Phone: (740) 366-6601
Fax: (740) 366-6286

149 N. High St./PO Box 1060
Hebron, OH 43025
Phone: (740) 928-7686
Fax: (740) 928-5585

PARENTAL/GUARDIAN CONSENT FORM

I, _____(parent/legal guardian) give my permission to *The* Mantonya Chiropractic Center and the Doctors within to perform the necessary diagnostic tests and to render the recommended treatments, thereafter to _____.

I also consent to billing any services performed to my insurance company (if applicable) and authorize the release of any information requested in order to process these claims.

A photocopy of this consent Form will be as effective and valid as the original.

Signature _____ Date _____
Parent/Legal Guardian

Signature _____ Date _____
Witness