

Pediatric New Patient Information & Auto Accident History Form

Today's Date _____

Name _____ Sex _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Child's Nickname _____ Child's SS # _____

Child's home phone # _____

Reason for Today's visit _____

Who may we thank for referring you: _____

Family Information

Mother's name: _____ Father's names: _____

Home phone #: _____ Home phone #: _____

Work phone #: _____ Work phone #: _____

Parent's marital status: Married: _____ Single: _____ Divorced: _____ Widowed: _____

List ages of other children in family: _____

Predominant language used at home: _____

Payment Information

Please read and sign our financial agreement.

Does your health insurance cover chiropractic? Y / N

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's name: _____ Date of Birth: _____ SS #: _____

Insurance company name: _____ Phone #: _____

Insurance company address to send claims: _____

Employer: _____ Group #: _____ Insured's ID #: _____

Consent to treat

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son / daughter named, _____ as the examining / treating doctor deems necessary.

I understand and agree I am personally responsible for payment of all fees charged by this office for such care.

Parent's name: _____ Signature: _____

Date: _____ Witnessed by: _____

About the accident

Date of the accident: _____ Time of day: _____ am / pm

Location of the accident: _____

Direction of the impact _____ Front end _____ rear-end _____ left side _____ right side _____ rollover

Did collision involve _____ another vehicle _____ other object

Non-collision injury _____ near miss _____ spin out _____ sudden stop

Child's position in vehicle _____ front-right _____ front-left _____ front-center
_____ rear-right _____ rear-left _____ rear-center

Car seat type _____ regular seat _____ infant seat _____ booster seat _____ facing front _____ rear

Was child wearing seat belt? _____ no _____ yes _____ lap/slash _____ lap only _____ harness

At time of accident child was _____ facing front _____ facing right _____ facing left _____ asleep _____ other

_____ Yes _____ No Were head rests fitted?

_____ Yes _____ No Did air bags inflate?

_____ Yes _____ No Was child struck by airbag?

_____ Yes _____ No Did the child strike any object within the vehicle?

Speed of vehicle _____ mph speed of other vehicle _____ mph

Make and model of your vehicle _____

Make and model of other vehicle _____

_____ Yes _____ No Was a police report file?

Describe the accident _____

Signed by: _____ date _____

Relationship to child _____

About the child's injuries

_____ Yes _____ No Does child have symptoms

If yes, please describe any apparent symptoms _____

_____ Yes _____ No Do you have any other concerns about your child's health? _____

_____ Yes _____ No Has the child been examined or treated since accident?

Name if hospital or treating doctor _____ Date _____

_____ Yes _____ No Were x-rays taken?

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Describe any treatments already received _____

Is child's condition _____ getting better _____ getting worse _____ constant _____ intermittent

When did symptoms start? _____ immediately _____ later that day _____ next day _____ days later

Does the child complain of any of the following

_____ Yes _____ No Pain or soreness? _____

_____ Yes _____ No Joint aches or stiffness? _____

_____ Yes _____ No Limited or painful motion? _____

_____ Yes _____ No Headaches? _____

_____ Yes _____ No Neck pain? _____

_____ Yes _____ No Dizziness? _____

_____ Yes _____ No Difficulty sleeping? _____

_____ Yes _____ No Irritability or fatigue? _____

_____ Yes _____ No Chest pain? _____

_____ Yes _____ No Abdominal pain? _____

_____ Yes _____ No Nausea? _____

_____ Yes _____ No Back pain or stiffness? _____

_____ Yes _____ No Leg pain? _____

_____ Yes _____ No Arm pain? _____

About your motor vehicle insurance company

Name of your auto insurance company _____

Claims Agent _____ Agent's phone number _____

Policy number _____ Claim number _____