

# PARTNERS IN HOLISTIC HEALTH, Inc.

## PEDIATRIC REGISTRATION FORM

(Please Print)

PATIENT INFORMATION					
Patient's LAST NAME:		FIRST:		MIDDLE:	
Street address:				SEX:	Home phone no.:
				<input type="checkbox"/> M <input type="checkbox"/> 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:			
<b>HOW DID YOU HEAR ABOUT US:</b>					
<b>EMAIL ADDRESS:</b>					
FINANCIAL RESPONSIBILITY & INSURANCE INFORMATION					
Person responsible for bill:					
NAME OF INSURANCE COMPANY:					Home phone no.:
					( )
Are you Covered by Insurance:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				Group #:	
Policy #	Co-payment	ID#		Employer phone no.:	
				( )	
<b>I WILL BE PAYING TODAY BY:</b> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD <input type="checkbox"/>					
<b>Make Checks to: PARTNERS IN HOLISTIC HEALTH</b>					
GENERAL INFORMATION					
NAME AND AGES OF BROTHERS AND SISTERS					AGE
1)					
2)					
3)					
Has your Child been Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes:</b> Recently? <input type="checkbox"/> Yes <input type="checkbox"/> No How Many Times? _____					
<b>*** PLEASE INCLUDE TYPE OF OPERATION OR ILLNESS &amp; LOCATION OF HOSPITALISATION ***</b>					
HOSPITALISATION (1)		HOSPITALISATION (2)		HOSPITALISATION (3)	
Do you have worrisome financial problems? : <input type="checkbox"/> Yes <input type="checkbox"/> No :			Do you have transportation problems getting here? : <input type="checkbox"/> Yes <input type="checkbox"/> No		
IF YES PLEASE EXPLAIN:					





