Pediatric Patient Registration Form

Last Name:	First Name:	M.I.
Parent's Last NAME:	FIRST NAME:	RELATIONSHIP TO CHILD
Address:		
City:	State:	Zip:
Cell phone:	Home phone:	Join our mailing list? Y/N
Phone # where we may leave private medical information? (Circle one) Cell or Home or Both		Date of Birth:
Email Address:		
Primary Care Physician:		Phone #:
Employer:		Occupation:
Emergency Contact:	Relation:	Phone #:
Allergies:		
How did you hear about W Clinic? ☐ Radio ☐ Newspaper ☐ Yelp ☐ Groupon ☐ Magazine ☐ Internet Search ☐ Direct Mail ☐ Physician Referral ☐ Friend/Family (please list person) ☐ Facebook other:		

_____ _____

Parent/Guardian Signature Date

W CLINIC OF INTEGRATIVE MEDICINE
PEDIATRIC INTAKE FORM

Patient Name:_____DOB/Age:_____

Sex: ___Male ___Female Grade in School (if Applicable):_____

Child's length/height: _____ Child's Weight:_____

Mother's Name and
Occupation:_____

Father's Name and
Occupation:_____

Parents are: ___ Married ___Separated ___Divorced ___Living together ___Other

Reasons for office
visit:_____

Has child been seen by any other doctors for this concern?: ___Yes ___No ___Past

Name of pediatrician and their
location:_____

Last time child has blood work done and with which
physician:_____
_____

List all child's surgeries and hospitalization with approximate date:
1)_____ 5)_____
2)_____ 6)_____
3)_____
4)_____

List all medicines (from drugstore or prescription) child is currently
using:_____
_____

List all supplements child is currently
taking:_____
_____

List any known allergies to foods, drugs, environment, or
animals:_____
_____

PREVIOUS MEDICAL HISTORY
*YES indicates the child gets the problem regularly
*NO indicates the child has never had the problem
*PAST indicates the child had the problem in the past but not recently

Ear infections: __yes __no __past How many total:_____
Colds: __yes __no __past How many total:_____
Strep throat __yes __no __past How many total:_____

How many times has the child taken antibiotics?_____

What other medications has the child taken and how often?_____
_____

Hearing tests normal: __yes __no __not tested

Vision tests normal: __yes __no __not tested

Speech impediments: __yes __no __past

Learning disabilities: __yes __no __past

VACCINATION HISTORY

MMR: __yes __no __some DPT: __yes __no __some

Hib: __yes __no __some Polio: __yes __no __some

Hep B:__yes __no __some Chicken pox: __yes __no __some

Other:_____

Any reactions to vaccinations (If Yes, Which Vaccine, What type of reaction occurred? Explain)?_____
_____

_____

FAMILY HISTORY

Allergies: __yes __no __past Tuberculosis: __yes __no __past

Diabetes mellitus: __yes __no __past Obesity: __yes __no __past

Mental illness: __yes __no __past Cancer: __yes __no __past

Cardiovascular Dz: __yes __no __past Other:_____

MOTHER'S PREGNANCY HISTORY

Age at conception:_____ Did mother have other children previously? __yes __no (If yes how many? ____)

Mother's Health During Pregnancy

Smoking: __yes __no Coffee: __yes __no Traumatic birth: __yes __no

Nausea/vomiting: __yes __no Diabetes: __yes __no Pre-eclampsia: __yes __no

Emotional stress: __yes __no Vaginal birth: __yes __no Drug use: __yes __no

Length of labor:_____ If birth was difficult, please explain:_____
_____

Health of baby at birth:_____

_____

HEALTH HISTORY OF CHILD

Child breastfed: __yes __no For how long?_____ When put on formula: _____

What type of formula (Cow, Soy, Goat)?_____ When were solid foods begun?_____

When did child walk?_____ Talk?_____ Develop teeth?_____

Jaundice as baby: __yes __no Colic: __yes __no

Cradle cap: __yes __no Anemia: __yes __no

Eczema/Psoriasis: __yes __no Asthma: __yes __no

Diarrhea: __yes __no Warts: __yes __no

Constipation: __yes __no Nightmares: __yes __no

Picky eater: __yes __no Bed-wetting: __yes __no

Poor teeth: __yes __no Tantrums: __yes __no

Chronic sniffles: __yes __no Disobedient: __yes __no

Bad foot odor: __yes __no Fears/Phobias: __yes __no

Diaper rash: __yes __no Early puberty: __yes __no

ADD/HD: __yes __no Stomach aches : __yes __no

Growing pains: __yes __no Breathing problems: __yes __no

Additional comments:_____
_____
_____

Parent or Guardian's Name_____

Signature of Parent or Guardian_____Date_____

Welcome to W Clinic of Integrative Medicine. We look forward to helping you achieve your health goals. This document contains important policy information that pertains to your treatment. Please read over the entire document. If you have any questions please feel free to ask us.

Appointments
Kindly provide 24 hours notice if you need to cancel or reschedule an appointment. Canceled or rescheduled appointments without appropriate notice will be assessed a fee of $100 for new patient consultations, $50 for established patient visits and $25 for all other services. We understand that emergencies do occur, and as a courtesy will allow one late-cancel or missed appointment at no charge. Following the first missed appointment we will be asking you for a credit card to hold your future appointment(s). Please note that insurance companies do not reimburse for missed appointments.

Payment
W Clinic of Integrative Medicine requires payment in full at the time services are rendered. I also understand that upon my request the cost of all procedures and services will be told to me before they are performed. For your convenience we accept Check, Cash, Visa, Mastercard or American Express payments. There will be a $25.00 fee for all returned checks.

Retail Return Policy
All supplement and other retail sales are final.

Refunds and Credits
Payment for services rendered is non-refundable. Payment for pre-paid services may be returned as a credit to your patient account at W Clinic. Patient account balances may be used for any service or products offered at W Clinic. Any credit issued has no cash value.

Emergencies
If you have a true medical emergency or serious medical concern please call 911 immediately. If you an a non-emergency health concern please call our office at 480-820-5026 between 8 am and 5 pm M-F, 9 am and 4 pm Sat. and we will schedule you as soon as possible to speak with/be seen for a medical visit by Dr. Weirick, Dr. Williamson(s) and/or Dr. Kaylee Thoreson and/or Dr. Emil Slovak Jr.

I have read this document completely and I understand and agree with all of its contents demonstrated by my signature below and my initials above.

Signature of Patient or Patient Representative Date

Informed Consent to Treat

Consent: I voluntarily consent to outpatient care provided by Dr. Susan Williamson Weirick NMD and/or Dr. John Williamson NMD and/or Dr. Phillip Williamson NMD and/or Dr. Kaylee Thoreson and/or Dr. Emil Slovak Jr. MD encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies including imaging studies), Intravenous therapies, injections, acupuncture, and administration of medications prescribed by the doctor.
I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.
I understand that not ALL of the treatment suggestions provided are accepted by the United States FDA and therefore should not be taken as such.

Type of Care: I understand that this medical practice uses some diagnostic and treatment methods that are variously known as, but not limited to: Naturopathic, environmental, complementary, alternative, integrative or nutritionally oriented. I agree to treatment using, but not limited to, nutrition, lifestyle, homeopathy, ozone therapy, manipulation, herbs, chelation therapy, acupuncture, pharmaceuticals, and intravenous and injection therapies.

Recital of Risks:
I understand and am informed that, as in the practice of naturopathic medicine/medicine, there are some risks to treatment, including, but not limited to: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness, allergic reactions to prescribed herbs, supplements, medications, aggravations of pre-existing symptoms.

Notice to all pregnant women: All female patients must alert their physician if they have a confirmed or suspected pregnancy as some of the therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pace maker and /or cancer, for your safety it is vital to alert your physician of these conditions.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

No Guarantee: I understand that results are not guaranteed.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I understand that this consent form will be valid and remain in effect as long as I receive medical care provided by Dr. Susan Williamson Weirick NMD and/or Dr. John Williamson NMD and/or Dr. Phillip Williamson NMD and/or Dr. Kaylee Thoreson and/or Dr. Emil Slovak Jr. MD.

Patient or patient representative signature Date

Dr. Susan Williamson Weirick NMD
Dr. John Williamson NMD
Dr. Phillip Williamson NMD
Dr. Kaylee Thoreson NMD
Dr. Emil Slovak Jr. MD
W Clinic of Integrative Medicine
2034 E. Southern Avenue
Suite P
Tempe, AZ 85282

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to view it.

Name: _____ Birthdate:_____

Signature: _____ Date: _____