

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? <input type="checkbox"/> RADIO <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> YELP <input type="checkbox"/> GROUPON <input type="checkbox"/> MAGAZINE <input type="checkbox"/> INTERNET SEARCH <input type="checkbox"/> DIRECT MAIL <input type="checkbox"/> PHYSICIAN REFERRAL <input type="checkbox"/> FRIEND/FAMILY (PLEASE LIST PERSON) <input type="checkbox"/> 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, initial each area and sign at the bottom; 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. 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 (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. Slovak. . k

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 Susan Williamson Weirick NMD and/or John Williamson NMD and/or Emil Slovak Jr. MD and/or Phillip Williamson NMD and/or Kaylee Williamson NMD and/or any physician/nurse practitioner employed or independently contracted with W Clinic of Integrative Medicine 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 practitioner. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medial 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 agreed to treatment using, but not limited to, nutrition, lifestyle, homeopathy, ozone therapy, manipulation, herbs, chelation therapy, acupuncture, pharmaceuticals, compounded medications, and intravenous and injection therapies.

Recital of Risks:

I understand and I 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, and side effects to prescribed herbs, supplements, medication, aggravation 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, clotting disorders, pacemaker 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/treatment which the doctor feels at the time, based upon the facts than known, is in my best interest.

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've 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 Susan Williamson Weirick NMD and/or John Williamson NMD and/or Emil Slovak Jr. MD, and/or Phillip Williamson NMD, and/or Kaylee Williamson NMD, and/or any physician employed or independently contracted with W Clinic of Integrative Medicine.

Patient or patient representative signature

Date



Dr. Susan Williamson Weirick NMD
Dr. John Williamson NMD
Dr. Emil Slovak Jr MD
Dr. Phillip Williamson NMD
Dr. Kaylee Williamson NMD

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: _____