

DR # _____

CASE # _____

**THE MANTONYA CHIROPRACTIC & WELLNESS CENTERS
PEDIATRIC PATIENT INTRODUCTION FORM**

(Please Print)

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

Mailing Address _____

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: **Windstream **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 Insurance? () Yes, () No

Primary Insurance Company Name _____ **Insured's ID#** _____

Insured's Name _____ **Insured's D.O.B.** _____

Secondary Insurance Company Name _____ **Insured's ID#** _____

Insured's Name _____ **Insured's D.O.B.** _____

FEES PAYABLE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE.



The Mantonya Chiropractic & Wellness Centers

Improving Lives with Expert Healthcare since 1971.

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MantonyaChiropractic.com

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

Print Name _____

Witness _____ Date _____