



Welcome to chiropractic ierano

PEDIATRIC INFORMATION

Parent's Names:

Child's first name _____ **middle** _____

preferred first name or nickname:(optional) _____

last name _____

Address _____
_____ **Postcode:** _____

Telephone home: _____ work: _____
mob: _____ email _____

Birthdate: _____ **Health Fund:** _____

How did you find out about this office ? _____ **may we thank them? YES NO**

Pension number: _____
Is this a **motor vehicle accident** claim ? YES NO

Parent's Work address: _____

Parent is Married ___ Single ___ Divorced ___ Other ___ No. of children: ___

Previous Chiropractor _____ **Medical advisor** _____
In case of **emergency**, contact: Name: _____
Ph:home _____ work _____

IF WE ACCEPT YOUR CHILD AS A PATIENT...
I understand and agree that Dr Ierano has the right to refuse to accept me as a patient before treatment begins. The taking of a *history* and conducting a *physical examination* are not considered treatment, but are part of the information gathering process needed to determine whether chiropractic can help me. My signature appears below:

/ / X
date Signature

--thank you