

**Welcome to our office. Please fill out the information below.**

**Thank you, Dr. Cruz & Staff**

**Please Print.**

**Date** \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent \_\_\_\_\_

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**Social Security Number** \_\_\_\_\_

**Telephone, Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_

**Address:**

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**E-Mail:** \_\_\_\_\_

**Parents**

**Married** \_\_\_\_, **Single** \_\_\_\_, **Divorced** \_\_\_\_, **Widowed** \_\_\_\_, **Number of Children:** \_\_\_\_

**What is your main reason for seeking a consultation and how long have you had it?**

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**Could you please let us know who referred you to our office so that we can be sure to thank them.**

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**OVER**

## **PAYMENT INFORMATION**

Do you have health insurance? Yes \_\_\_\_\_, No \_\_\_\_\_

**PLEASE NOTE:** The cost of your exam and x-rays are to be paid on the day of service. Please give the receptionist your insurance card so we can make a copy.

Will you be paying with: Cash \_\_\_\_\_, Check \_\_\_\_\_, Credit card \_\_\_\_\_

I request that you file my insurance \_\_\_\_\_

I request that financial arrangements be made for payment \_\_\_\_\_

**WE WILL DO OUR BEST TO NOTIFY YOU OF ALL  
POSSIBLE COSTS BEFORE PROCEEDING.**

Please list the number of doses of antibiotics your child has taken in the last

**6 Months:** \_\_\_\_\_. **Date of last vaccination:** \_\_\_\_\_

Please list any medications your child is taking & for what reason: \_\_\_\_\_

**Birth Intervention:** \_\_\_\_ Forceps, \_\_\_\_ Vacuum Extraction, \_\_\_\_ C Section.

Are there any genetic disorders or disabilities that you know of? \_\_\_\_\_

**FEEDING HISTORY:** Breast Fed: \_\_\_\_ yes, \_\_\_\_ No, How Long: \_\_\_\_\_

Formula Fed: \_\_\_\_ Yes, \_\_\_\_ No, How Long: \_\_\_\_\_ Cows milk fed at \_\_\_\_ months.

List any allergies you know of: \_\_\_\_\_

According to the National Safety Council, 50% of children fall from a high place in the first year of their life (bed, changing table, chair, steps, car accidents, etc.) Has this happened to your child? \_\_\_\_ Yes, \_\_\_\_ No.

Has your child ever been seen on an emergency basis: \_\_\_\_ Yes, \_\_\_\_ No, When: \_\_\_\_\_

Please list any other trauma not covered: \_\_\_\_\_

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Signature \_\_\_\_\_ Date \_\_\_\_\_