PEDIATRIC REGISTRATION FORM *Please Print* ☐ MALE ☐ FEMALE

Name_____ Birth Date___/___/___
LAST FIRST MI

Address_____ City_____ State_____ Zip_____

Home Phone (___)_____ Parent's Work (___)_____

Social Security #_____ Parent's Cell (___)_____

Email Address _____

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Never Married

Referred By_____

PERSON RESPONSIBLE FOR PAYMENT:

Name_____ Relationship_____ DOB_____

Employed By_____ Social Security #_____

Insurance_____ Policy No._____

PERSONS TO CONTACT IN CASE OF EMERGENCY

Name_____ Phone # (___)_____

Name_____ Phone # (___)_____

CANCELLATION/RESCHEDULE POLICY:

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, PLEASE NOTIFY OUR OFFICE 3 BUSINESS PRIOR, OR YOUR ACCOUNT WILL BE CHARGED THE FULL AMOUNT OF YOUR APPOINTMENT. **PAYMENT IS DUE AT TIME OF VISIT BY EITHER CASH, CHECK, OR CREDIT CARD.**

WE REQUIRE that you or others accompanying you **NOT** wear colognes, perfumes, scents, or scented lotions the day of your child's visit. **We keep a scent free office for people with chemical sensitivities.**

Please sign and return at least one week prior to your child's appointment. WE WILL NEED BOTH PARENTS' CONSENT.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT. I UNDERSTAND THE CANCELLATION POLICY AND PAYMENT POLICY. I HEREBY CONSENT TO MEDICAL AND HOMEOPATHIC TREATMENT BY JEFF D. LESTER, D.O.

SIGNATURE_____ DATE_____

SIGNATURE_____ DATE_____

PEDIATRIC INFORMATION

Name_____ Date_____
Last First MI

Name commonly called *(if different from above)*_____

CURRENT PROBLEMS Date of Onset

1._____ _____
2._____ _____
3._____ _____
4._____ _____
5._____ _____

PAST PROBLEMS Date

1._____ _____
2._____ _____
3._____ _____

FURTHER DESCRIPTIONS OF PROBLEMS

_____
_____
_____
_____

SURGERIES OR HOSPITALIZATIONS Date

1._____ _____
2._____ _____
3._____ _____

MEDICATIONS:	Dose	Date

PEDIATRIC INFORMATION

Name_____
Last First MI

LIVING SITUATION Members at Home

	NAME	AGE	RELATIONSHIP
1.			
2.			
3.			
4.			
5.			

SIBLINGS NOT LIVING AT HOME

	NAME	AGE
1.		
2.		
3.		

PETS AT HOME

1._____ 3._____
2._____ 4._____

ALLERGIES (Medications, Foods, Environment)

SUBSTANCE	REACTION

BIRHT HISTORY

Place of Birth_____ Birth Weight_____ Weeks Gestation_____
Maternal Problems During Pregnancy_____
_____
_____
Problems During Labor_____
_____
_____

PEDIATRIC INFORMATION

Name_____
Last First MI

Number of Months Breastfed:_____

IMMUNIZATIONS *(Please bring your Immunization card)*

Immunizations Given: (Circle one) All on Time Delayed None

Significant vaccine reactions, if any:_____

_____

Has the child had any of these problems? *(Please check)*

_____	Trouble Sleeping	_____	Excess Body Heat
_____	Nightmares	_____	Eczema
_____	Frequent Ear Infections	_____	Psoriasis
_____	Headaches	_____	Warts
_____	Speech Impediment	_____	Serious Accident
_____	Frequent Sore Throats	_____	Shyness
_____	Asthma	_____	Fears
_____	Whooping Cough	_____	Overly Clingy
_____	Gastric Reflux	_____	Temper Fits
_____	Frequent Stomach aches	_____	Breaks or Throws things
_____	Constipation	_____	Fighting
_____	Bed Wetting (Over 4 years Old)	_____	Lying
_____	Discharge from Genitals	_____	Nervous Habits
_____	Excessive Weight Loss	_____	Family Problems
_____	Excessive Weight Gain	_____	Vision Impaired

Additional Comments or Special Problems_____

_____

_____

_____

Family Medical History Describe significant illnesses of family members or symptoms that tend to run through your heritage, including mental/emotional (ie. Arthritis, Cancer, Heart disease, Depression).

_____

_____

_____

_____

_____

HEAD, EYES, NOSE & THROAT:

RESPIRATORY:

CARDIOVASCULAR:

GASTROINTESTINAL: *(Any Scoping with Dates)*

RECTAL TROUBLE: *(Constipation, Diarrhea, Anal Itching, Fissures, Hemorrhoids)*

URINATION:

DERMATOLOGICAL: *(Rashes, Sweat, Acne Treatments)*

SPINE & EXTREMITIES: *(Specify Neck or Back Abnormalities—i.e. Cramping, Pain or Numbness)*

SLEEP:

DREAMS: *(Recurrent Themes)*

ENERGY: *(When Low & High)*

TEMPERATURE: *(Generally feel warm or chilly)*

TIME OF DAY PROBLEMS OCCUR:

OTHER:

E-MAIL AGREEMENT

Trilogy Medical, Inc.
Jeff D. Lester, D.O.
280 W Hamilton Ave
Campbell, CA 95008
Phone (408) 844-0010 Fax (669) 300-6912
info@trilogymedical.net

E-Mail is a welcome way to consult with our office regarding problems and questions.
No emergency material is to be communicated by e-mail.

For Doctor to read e-mails:

$40.00	½ page
$60.00	Full page

There is no charge for the staff to receive e-mails regarding setting up an appointment or sending remedies.

REMEDY BY MAIL

Homeopathic remedies can be sent to you by mail, by the following procedures;

1. Call or e-mail with which remedy or remedies are needed ie: daily dose, booster dose(LM1) or high dose.

2. Include your credit card number if not already on file. For efficiency please arrange to have your credit card on file (your number will be protected).

3. Shipping and Handling is $8.00.

Credit Card Number (Visa, Mastercard, American Express Accepted). Please include your expiration date:

_____

_____ _____

I understand & agree with the above policies Date