Trilogy Medical
CENTERS FOR INTEGRATIVE MEDICINE

PEDIATRIC PATIENT REGISTRATION FORM

☐ MALE ☐ FEMALE

Please Print

Name ____ Birth Date ______________
Last First M

Address ___________________________ City ____________ State _____ Zip _________

Mother's Name ________________________ Father's Name _________________________

Mother's Ph# _________________________ Father's Ph# __________________________

Mother's Email ________________________ Father's Email ________________________

Parents' Marital Status Married ☐ Divorced ☐ Widow ☐ Never Married ☐

Guardian's Name ______________________ Guardian's Ph# ________________________

Referred By ____

PERSON RESPONSIBLE FOR PAYMENT:

Name _______________________________ Relationship ____________ DOB ___________

Employed By ____

Insurance Company __________________________ Policy# __________________________

PERSONS TO CONTACT IN CASE OF EMERGENCY:

Name _____________________________ Relationship ___________ Phone# ______________

Name _____________________________ Relationship ___________ Phone# ______________

CANCELLATION/RESCHEDULE POLICY:

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, PLEASE NOTIFY OUR OFFICE AT LEAST 3 BUSINESS DAYS PRIOR, OR YOUR ACCOUNT WILL BE CHARGED THE FULL AMOUNT OF YOUR APPOINTMENT.

WE REQUIRE you or others accompanying you to not wear colognes, perfumes, scents, essential oils, or scented lotions to the office. We keep a scent free office for people with chemical sensitivities.

PLEASE SIGN AND RETURN IN ADVANCE OF YOUR APPOINTMENT IF POSSIBLE.
WE WILL NEED BOTH PARENTS' SIGNED 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 DR. JEFF LESTER, D.O.

SIGNATURE_______________________________ Relationship ____________ DATE___________

SIGNATURE_______________________________ Relationship ____________ 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
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

BIRTH HISTORY

Place of Birth______________________ Birth Weight________ Weeks Gestation__________

Maternal Problems During Pregnancy____
____
____

Problems During Labor____
____
____

TRILOGY MEDICAL
Centers for Integrative Medicine

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:

Trilogy Medical
CENTERS FOR INTEGRATIVE MEDICINE

Trilogy Medical, Inc.

4105 Soquel Dr, #A
Soquel, CA 95073
(831) 600-8117 Phone
(831) 600-8811 Fax
staff@trilogymedical.net
www.trilogymedical.net

EMAIL

Email is a way to correspond for general matters, but please
DO NOT SEND EMERGENCY OR URGENT INFORMATION BY EMAIL.

REMEDIES BY MAIL

To have homeopathic remedies sent to you:

1. Call or email with which remedy or remedies are needed (name and dosage).
2. Confirm the address you want it sent to and any special delivery requests.
3. Relay the cc# to be used (security protected) for the items plus shipping cost.

CANCELLATION/RESCHEDULE POLICY

If you need to reschedule or cancel your appointment for any reason, please notify our office at least 3 business days prior, or your account will be charged the full amount of your appointment. We appreciate your cooperation. Payment for initial visits are due in advance, and follow up visits are due at the time of visit.

Credit Card Number (Visa, Mastercard, Discover Accepted).

_______________________ Credit Card Number

_______________ Expiration Date

_______________ Code# (3 digits on back of card)

_______________ Billing Zip Code

_______________________________ I understand & agree with the above policies

_______________ Date

Acknowledgement of Receipt of

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our office.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary. By signing below, I certify that I have read and understood the Notice of Privacy Practices.

Patient Name ________________________________

Patient Signature______________________________ Date:____________