



Child Intake Form

MAIN OFFICE—5411 State Road 50, Delavan WI 53115

Phone: (262) 740-3000 FAX: (262) 740-3001

SKYPE NAME: [elementals.living](https://www.elementalsliving.com)

www.elementalsliving.com

Personal Medical Information

Please print legibly. This form needs to be submitted prior to your appointment to ensure timely process.

Date: _____

Patient Name: _____
Last First

Responsible Party Name: _____
Last First

Street Address: _____

City State Zip Country

Home Phone: _____ Cell Phone: _____

Work Phone: _____ FAX: _____

Email address: _____ Skype Acct Name: _____

Preferred method of contact: _____

Legal Status Caregiver: Parent
Legal Guardian (need documentation)
Non-Custodial Caregiver

Patient's Date of Birth: _____ Age: _____ Sex: _____ Patient's Blood Type: _____
Height: _____ Weight: _____
Known drug allergies: _____

Primary Care Physician _____ Specialty _____

Phone: _____

Address: _____

Insurance Company: _____
(Disclaimer: We do not accept Insurance and are not a Medicare provider. This information is for office use only.)

Patient's Name: _____

Medication Name	Medical Condition	Start Date	End Date	Dosage	Reaction/Side Effect

Please list the current supplements that patient is taking:

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Please list current therapies/progress:

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Current Diet:

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Known Food Allergies:

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Known Environmental Allergies:

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Pregnancy/Birth Information:

Delivery Type:	Weight:
Medication used during pregnancy:	
Chemical exposures:	
Rhogam?	
If premature delivery, how early?	
Other birth complications:	
Breast or bottle fed:	If breast fed, how long?
If formula which one:	Any formula problems:
Age child started dairy products?	Noted dairy issues:

Patient's Name: _____

At what age did child do the following?

Sit without assistance	Pincer/Grasp	Smile
Stand without support	Cruise	Walk
Roll Over	Transfer Objects hand to hand	Crawl
Babble	First words	Link 2 to 3 words
Pull to stand	Social Smiles	Interactive play
What age did your child point	Does your child point now?	Point to request things
Point to show you something		

Immunizations:	Date	Date	Date	Date	Date	Reactions
DTaP						
DTP/TD						
Oral Polio						
MMR						
Flu Shots						
Pevnar						
Hep B						
Varicella- (chickenpox)						
Other						
						Or attach vaccine record

Describe Sleep History

Autistic Characteristics, if applicable:

<input type="checkbox"/> Stimming/how much _____	<input type="checkbox"/> Tantrums	<input type="checkbox"/> Pica	<input type="checkbox"/> Cries a lot	<input type="checkbox"/> Hitting Self
<input type="checkbox"/> Repetitive Play	<input type="checkbox"/> Regression			

Patient's Name: _____

Family Member	Health Status	Arthritis	Cancer	Diabetes	Heart Disease	Lung Disease	Mental Illness	Stroke	Other
Father									
Mother									
Siblings									
Siblings									
Siblings									
Siblings									
Siblings									
Siblings									
Children									
Children									
Children									
Children									
Children									
Children									
Children									

Patient's Name: _____

PATIENT BILL OF RIGHTS

Elementals Living, LLC is dedicated to quality patient care. We realize that patients and providers share responsibilities in achieving the best possible health care.

Patients' Rights

- Courteous, considerate, and respectful treatment at all times.
- Candid discussions of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit options.
- Access to preventive health care services.
- Information about benefits, where and how to seek care, and the risks involved in treatment.
- Timely response to requests for services, inquiries, and complaints.
- Second opinion when medically appropriate.
- Titles and specialties of the health care professionals responsible for your care.
- Privacy and confidentiality regarding your medical and health conditions.
- Recognition of your rights to make decisions regarding your medical care.

Patients' Responsibilities

As your healthcare partner, we ask that you:

- Provide professional staff with all pertinent health care information needed to ensure the best possible outcome.
- Communicate when you have questions or concerns about your health care.
- Adhere to instructions and guidelines given for health care services.
- Be aware of your health benefits and services and how to correctly obtain them.

GENERAL CONSENT TO CARE

General Consent to Care

I, the undersigned, hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Elementals Living.

Billing Policy

It is our policy that patients pay for all services and supplements at the time of your scheduled appointment. A 72 hour notice of a cancelled appointment is required, otherwise a fee of \$100.00 will be charged to your account. It is the patient's responsibility to file insurance claims to their carrier. A universal insurance form will be provided along with all the necessary information so that claims can be filed properly. Credit Cards and Personal checks are accepted. Returned checks will incur an additional \$30.00 fee.

Financial Responsibility

I understand that I am financially responsible to **Elementals Living** and I agree to pay Elementals Living for all charges rendered at time of service.

Insurance

Elementals Living does not contract with any insurance plans. Elementals Living is NOT a Medicare Provider and patients who have Medicare will need to sign our Medicare Opt out form prior to being seen by Doctor.

Case Management Fee

I understand that there is a charge for case management and medical letters.

Notice to Patient's Responsible Party:

- Dr. Hicks does not practice routine care as a Primary Care Physician. In case of an emergency, please contact your Primary Care Physician or call 911.
- Dr. John H. Hicks routinely utilizes the services of a "medical intuitive" when assessing patients. There is no scientific research to support the validity of the medical intuitive contribution to your care. If you would prefer that the medical intuitive not be involved in your care, you have the right to inform Dr. Hicks and he will treat you without the involvement of the medical intuitive.

I certify that I have read these policies and agree to abide by all requirements.

**Parent/Guardian
Signature** _____

Date _____