Points of Origin, PLLC
18810 NE 18th Street
Vancouver, WA 98684

Peter Hanfileti, MD
Lisa Hanfileti, LAc
Phone: 360-449-4500

NEW PATIENT REGISTRATION & INTAKE FORM Appt Date: : _____/_____/_____
(please feel free to attach any additional information)

Child's Name _____ Nickname _____
Child's Birth Date: _____/_____/_____ Age: _____ Male / Female Ht_____ Wt_____

Parent's Name(s) _____
Mailing Address _____ City_____
State _____ Zip_____
Preferred Phone (circle) Work / Cell / Home # (_____)_____
Preferred Email Address_____
Permission to Email / Call Appt Reminders: Y / N Permission to Email Receipts & Newsletter Y / N
Emergency Contact Name and Phone #_____

Health Insurance Name & Subscriber ID#_____
Primary Insured: _____ Birth Date: _____/_____/_____

Reason for visit _____
_____
_____
_____
_____
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_____
_____
_____
_____
_____
_____
_____
_____
Any additional health concerns_____
_____
_____
_____
_____

Is your child under the care of a physician/specialist now? Y / N
If Yes, for what diagnosis?_____
Name of child's Primary Care Physician (PCP)? _____
Clinic Name & Phone#_____ Permission to contact your PCP: Y / N
Other current therapies_____
Other therapies tried in the past_____
Any Pets? Y / N Type of Pets & general health _____

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Family Medical History (i.e. significant illnesses that may run in the family. Indicate who is/was affected with: **G-G**randparents, **P-P**arents, **S-S**iblings):

_____
_____
_____
_____
_____
_____

Child's Past Medical History (include hospitalizations, illnesses, accidents, traumas, etc.):

_____
_____
_____
_____
_____
_____
_____

Prescription Medications currently taking (indicate dosage, how many times per day, when started):

_____
_____
_____
_____
_____
_____
_____

Vitamins/Supplements currently taking (indicate dosage, how many times per day, when started):

_____
_____
_____
_____
_____

To the best of my knowledge the information provided on this form is true and accurate.

Signature:_____

Printed Name:_____

Please do not write below this line. For office use only.