Stephen Cowan MD FAAP
Tel: 914-864-1976 Fax: 914-864-1967

491 Lexington Ave.
Mt. Kisco, NY 10549

29 W 57th St.
NY, NY 10019

New Patient Intake Form

Date________________________

The name of your child ____

What does your child like to be called?____

Date of birth ____

Guardian's name ____

Home Address ____

____

Home Telephone Number____

Work Telephone ____________________________Cell Phone _________________________________

Email address____

Parents Profession ____

Your child's Primary Physician_ ____

Permission to contact child's health care providers: Yes ___No ___ Signature ________________

How did you hear about Dr. Cowan? ____

Reason For Consultation (in brief):

Please read and initial that you have read and understand the following two statements:

1. **The nature of the role of the Holistic Consultation is to provide a service that will complement your routine medical care. You are advised to continue to be followed by your primary care physician and other medical specialists for any medical conditions.**

   Acknowledgment- Initial ______________

2. **Dr. Cowan, in his role as consultant at the Center does NOT participate with any insurance plans at this office. Payment is due at the time service is rendered. You will receive a super bill that you may submit to your insurance company but recognize that he is not responsible for any reimbursement.**

   Acknowledgment- Initial _______________

3. **Cancellation notification of a scheduled appointment must be received at least 24 hours prior to the appointment otherwise you will be charged for the visit.**

   Acknowledgment – Initial _____________

CURRENT DIAGNOSES (if any):

SPECIALISTS/THERAPISTS CURRENTLY WORKING WITH YOUR CHILD:

CURRENT SCHOOL INFORMATION

PRENATAL/BIRTH HISTORY

IVF___Vaginal___C/S___Full Term ____Preterm___ Breast-fed ___
Adopted___Surrogate___

FAMILY HISTORY

Marital Status:

Siblings Names and Ages:

Please check off any medical conditions that family members may have a history of:

Condition	Yes	Maternal family	Paternal Family
Attention Deficit Disorder			
Autism Spectrum Disorder			
Mental Retardation			
Learning Disability			
Genetic Syndromes			
Asthma/Allergies			
Chronic Headaches			
Digestive problems			
Arthritis			
Autoimmune disorders			
Depression/Bipolar			
Anxiety			
Substance Abuse			
Obsessive Compulsive Disorder			
Other			

Please recognize that this is merely a general overview of your child's history. We will be going into greater depth about the particulars of your child's condition at the time of the first visit.

MEDICAL RECORDS

Please include copies of evaluations, laboratory tests, vaccinations received and any other information you feel is important for us to review.

All information is confidential and will not be shared with any other person without specific consent from you.

Thank you,

Stephen Cowan, MD, FAAP