Confidential Patient Information – Children

Date: _____

Child's Name: _____Nickname: _____

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: _____Birth Date: _____ Age: _____

Sex: M F Social Security# _____

Mother's Name: _____ Father's Name_____

Home Phone # _____ Home Phone #_____

Work Phone # _____ Work Phone # _____

Who has legal custody of child? Both Parents Mother Father Other _____

Parent's Marital Status: M S D W

List names and ages of other children in family: _____

How did you find about our office? Friend or Family Advertising Phone Book Sign Health Fair

Who may we thank for referring you? _____

Family Medical Doctor: _____Address_____

May we have your permission to update your medical doctor regarding your child's care at our office?

YES NO

PLEASE CHECK ANY AND ALL INSURANCE COVERAGE THAT MAY BE APPLICABLE IN THIS CASE:

_____ Major Medical _____ Medical Savings & Flex Plans _____ Auto Accident _____ Other

Primary Insurance: _____ Insured's Name _____ DOB _____

Secondary Insurance: _____ Insured's Name _____DOB _____

PLEASE ALLOW US TO COPY YOUR INSURANCE CARD

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

PLEASE CONTINUE ON NEXT PAGE

Health History

Reason for this visit: _____

Date symptoms appeared or accident happened: _____

Has child ever had the same or a similar condition? Yes No If yes, when and describe: _____

_____

Please list any major illnesses, injuries, falls, or surgeries: _____

_____

Has your child been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs is child taking? _____

Please list any other health problems your child has, no matter how insignificant they may seem:

_____

_____

PRIVACY INFORMATION

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

CONSENT FOR CHIROPRACTIC CARE

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter (name) _____ as the doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

(If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____