Pediatric New Patient Form

CHILD'S NAME____ DATE_______________________
PARENT/GUARDIAN NAME (S)____
____
STREET ADDRESS____
CITY____ STATE_______________ ZIP___________
PHONES: HOME_____________________ WORK___________________ CELL______________
BIRTHDATE__________________ AGE___________ SCHOOL GRADE____________________
REFERRED BY______________________________________

Describe Primary Health Concern____
____

Rate your concern:
(0=no problem 10=most severe) 0 1 2 3 4 5 6 7 8 9 10

How/When did it begin____
Any Previous Treatment____
Made Better By____________________________ Made Worse By________________________
Any Other Concerns____
Prior Injuries (Include Dates)____
Surgeries/Hospitalizations (Include Dates) ____
Circle and Describe any of the following that apply:
Birth Trauma ____
Chronic Earaches____
Frequent Colds____
Allergies to MEDICATIONS OR FOODS____
Sinus Problems____
Diarrhea/Constipation____

Antibiotic Use If Ever: Age When First Taken_____________________________________
Describe history of antibiotic use____
Current Medication(s)____
List Herbs or Vitamins Taken Regularly____
____

Currently Under Care of a Practitioner: YES NO
If Yes, Practitioner's Name:__________________________________
Previous Chiropractic Care YES NO Practitioner's Name:__________________________

Average Hours Sleep / Night____
Soft Drinks NO YES Frequency____
Candy/Sweets NO YES Frequency____
Caffeine NO YES Form and Frequency________________________________
Tobacco or
Secondhand Smoke NO YES Forms and Frequency____________________________

PLEASE READ THE FOLLOWING BEFORE SIGNING:

I hereby authorize Dr. Erika Grushon or Dr. Katherine Hulbert and whomsoever they may designate as assistants to administer chiropractic care as deemed necessary to my son/daughter (Child's Name) ____
Signature of Parent/Guardian______________________________ Date____________

Payment is required at the time of service. Please check which method (s) of payment you prefer:

☐ CASH ☐ CHECK ☐ CREDIT/ DEBIT (Visa, MasterCard, Discover)

At your request we will gladly provide you with statements to use for insurance reimbursement.

☐ Check this box if you think you may file with your insurance company at any time in the foreseeable future.

- Please be aware that by making an initial appointment with our doctors, you are agreeing to abide by the billing policies of our practice. You will be charged for your appointment if you forget it or do not provide at least 24 hours notice of a cancellation or change in your appointment date/time. Exceptions will be made for weather and/or emergency situations.
- We invite you to discuss with us any questions regarding our services. The best care is based on a friendly, mutual understanding between chiropractor and patient. We want to be part of your health care team.

By signing below:

- I authorize the staff and chiropractic physicians to perform any services needed during diagnosis and treatment.
- I authorize the provider to release any information required to process insurance claims. I understand and agree that health insurance is an agreement between the carrier and myself and that all services rendered are charged directly to me and that I am personally responsible for payment, even if I terminate my care.
- I understand any and all information collected in this office is confidential and I also understand it is my responsibility to inform this office of any changes to the information I have provided.
- I acknowledge that I have read and understand the HIPAA Privacy Act. **INITIAL HERE:** ____

SIGNATURE ______________________________ **DATE** ______________