

PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME: _____ MOTHER'S NAME: _____ DOB: _____
CASE NUMBER: _____ FATHER'S NAME: _____ DOB: _____
ADDRESS: _____ CITY/TOWN: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ MOTHER'S WORK PHONE: _____ MOTHER'S CELL PHONE: _____
EMAIL: _____ FATHER'S WORK PHONE: _____ FATHER'S CELL PHONE: _____

BIRTH DATE: _____ AGE: _____ SEX: _____ NUMBER OF SIBLINGS: _____ REFERRED BY: _____
BIRTH WEIGHT: _____ BIRTH LENGTH: _____ CURRENT WEIGHT: _____ CURRENT LENGTH: _____

THIRD TRIMESTER PRESENTATION: VERTEX _____ BREECH _____ TRANSVERSE _____ FACE/BROW _____
TYPE OF BIRTH: NORMAL VAGINAL _____ FORCEPS _____ CESAREAN _____ SUCTION CAP OR VACUUM _____
LOCATION: HOME _____ BIRTHING CENTER _____ HOSPITAL _____
PROBLEMS DURING PREGNANCY: _____
PROBLEMS DURING LABOR/DELIVERY: _____
APGAR SCORES: _____ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)? _____ CYANOSIS (BLUE)? _____
CONGENITAL ANOMALIES/DEFECTS? _____ IF YES, PLEASE EXPLAIN? _____

INFANT FEEDING: BREAST _____ BOTTLE _____ IF BOTTLE, WHICH FORMULA? _____
NUMBER OF HOURS SLEEPING PER NIGHT: _____ QUALITY OF SLEEP: GOOD _____ FAIR _____ POOR _____

OBSTETRICIAN/MIDWIFE: _____
PEDIATRICIAN/FAMILY MD: _____
DATE OF LAST VISIT: _____ PURPOSE: _____
IMMUNIZATION HISTORY: _____
NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: DURING THE PAST SIX MONTHS _____ DURING HIS/HER LIFETIME _____
PREVIOUS CHIROPRACTOR: _____
DATE OF LAST VISIT: _____ PURPOSE: _____
HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? _____ IF YES, PLEASE EXPLAIN: _____

PURPOSE OF THIS APPOINTMENT: _____
INSURANCE/BILLING INFORMATION: _____ POLICY #: _____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY
SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

SIGNED: _____ WITNESSED: _____ DATE _____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I AGREE TO PAY FOR ALL SERVICES PROVIDED.
X-RAYS REMAIN THE PROPERTY OF THIS OFFICE.

SIGNED: _____ DATE _____

PEDIATRIC CASE HISTORY

DELIVERY/BIRTH HISTORY: _____

AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND _____ FOLLOW AN OBJECT WITH HIS/HER EYES _____ HOLD HEAD UP _____
SIT ALONE _____ CRAWL _____ STAND _____ WALK ALONE _____

AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES?

CHICKENPOX _____ MUMPS _____ MEASLES _____ RUBELLA _____
RUBEOLA _____ WHOOPING COUGH _____ OTHER _____

HAS THIS CHILD EVER SUFFERED FROM:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> ORTHOPEDIC PROBLEMS | <input type="checkbox"/> DIGESTIVE DISORDERS | <input type="checkbox"/> BEHAVIORAL PROBLEMS |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> NECK PROBLEMS | <input type="checkbox"/> POOR APPETITE | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> FAINTING | <input type="checkbox"/> ARM PROBLEMS | <input type="checkbox"/> STOMACH ACHES | <input type="checkbox"/> RUPTURES/HERNIA |
| <input type="checkbox"/> SEIZURES/CONVULSIONS | <input type="checkbox"/> LEG PROBLEMS | <input type="checkbox"/> REFLUX | <input type="checkbox"/> MUSCLE PAIN |
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> JOINT PROBLEMS | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> GROWING PAINS |
| <input type="checkbox"/> CHRONIC EARACHES | <input type="checkbox"/> BACKACHES | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> ALLERGIES TO _____ |
| <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> POOR POSTURE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> ALLERGIES TO _____ |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> ALLERGIES TO _____ |
| <input type="checkbox"/> COLDS/FLU | <input type="checkbox"/> WALKING TROUBLE | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> COLIC | <input type="checkbox"/> BROKEN BONES | <input type="checkbox"/> BED WETTING | <input type="checkbox"/> OTHER _____ |

HAS THIS CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?

- | | | |
|---|---|--|
| <input type="checkbox"/> FALL IN BABY WALKER | <input type="checkbox"/> FALL FROM BED OR COUCH | <input type="checkbox"/> FALL OFF SKATEBOARD OR SKATES |
| <input type="checkbox"/> FALL FROM CRIB | <input type="checkbox"/> FALL OFF SWING | <input type="checkbox"/> FALL OFF BICYCLE |
| <input type="checkbox"/> FALL FROM HIGHCHAIR | <input type="checkbox"/> FALL OFF SLIDE | <input type="checkbox"/> FALL DOWN STAIRS |
| <input type="checkbox"/> FALL FROM CHANGING TABLE | <input type="checkbox"/> FALL OFF MONKEY BARS | <input type="checkbox"/> OTHER _____ |

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? _____ IF YES, PLEASE EXPLAIN: _____

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT? _____ IF YES, PLEASE EXPLAIN: _____

PRESENT HISTORY: _____

SURGERY: _____

MEDICATIONS: _____

ACCIDENTS: _____

FAMILY HISTORY: _____

Bayside Chiropractic
Dr. Leslie M Bryan
11322 US Highway 31
Daphne, AL 36527

PLEASE PRINT

Name _____

File# _____

Telephone Communication Preferences

<u>Location</u>	<u>Number</u>	<u>Can we call you here?</u>		<u>Can we leave a message?</u>	
Home	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Work	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cell	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Mail Communication Preferences - **PERSONAL OFFICE USE ONLY!***

May we send mail to your home address? (For example, Birthday Cards, Promotional Cards, Newsletters, etc)

If no, please provide an Alternate mailing address below.

☐ Yes ☐ No

Other than you, your insurance company, and health care providers involved in your care, whom can we talk about your health care information? (Check all that apply)

	<u>Name</u>	<u>Telephone</u>
<input type="checkbox"/> Spouse	_____	_____
<input type="checkbox"/> Caretaker	_____	_____
<input type="checkbox"/> Child	_____	_____
<input type="checkbox"/> Parent	_____	_____
<input type="checkbox"/> Other	_____	_____

Do you have any health information that you would like to be kept confidential from any person or persons?

If so, please specifically describe the information and person or persons below:

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Patient or personal Representative Signature

Date

Printed Name Relationship to Patient

Relationship to Patient

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. Including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic who now or in the future treat me while employed by, working, or associated with, serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with office or clinical personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but limited to: fracture, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

To be completed by patient's representative. If necessary, e.g., if patient is a minor or is physically or mentally incapacitated:

Print Patient's Name

Print Name of Patient

Patient's Signature

Print Name of Patient's Representative

Date Signed

Signature of Patient's Representative

As _____
Relationship or Authority of Patient's Representative

Date Signed

To be completed by Doctor or staff:

Name and address of clinic/office:

Bayside Chiropractic
Dr. Leslie M Bryan
11322 US Highway 31
Daphne, AL 36527

Print name(s) of doctor(s) treating this patient:

Dr. Leslie Bryan

Dr. Timika Frazier

Witness to Patient's Signature

Date

ASSIGNMENT OF BENEFITS & HIPAA RELEASE FORM

Please check any and all insurance coverage that may be applicable in this case:

- ☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

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.

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.

Patient Signature: _____ Date: _____

Guardian Signature Authorizing Care: _____ Date: _____