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:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to _____
☐ Sinus Trouble	☐ Poor Posture	☐ Diabetes	☐ Allergies to _____
☐ Asthma	☐ Scoliosis	☐ Hypertension	☐ Allergies to _____
☐ Colds/Flu	☐ Walking Trouble	☐ Anemia	☐ Other _____
☐ Colic	☐ Broken Bones	☐ Bed Wetting	☐ Other _____

Has this child ever suffered the following spinal traumas?

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from highchair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ 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
11280 # A Hwy 31
Spanish Fort, AL 36527

PLEASE PRINT

Name_____

File# _____

Telephone Communication Preferences

Location	Number	Can we call you here?		Can we leave a message?	
Home	_____	☐ Yes	☐ No	☐ Yes	☐ No
Work	_____	☐ Yes	☐ No	☐ Yes	☐ No
Cell	_____	☐ Yes	☐ No	☐ Yes	☐ No
Other	_____	☐ Yes	☐ No	☐ Yes	☐ 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)

	Name	Telephone
☐ Spouse	_____	_____
☐ Caretaker	_____	_____
☐ Child	_____	_____
☐ Parent	_____	_____
☐ Other	_____	_____

Do you have any health information that you would like to be kept confidenrial 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 an 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:

_____
Print Patient's Name

_____
Patient's Signature

_____
Date Signed

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

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
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
11280 #A Hwy 31
Spanish Fort, AL 36527

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

Dr. Leslie Bryan
Dr. Crystal Wachtel

_____
Witness to Patient's Signature

Date

ASSIGNMENT OF BENEFITS & HIPPA 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 are, 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 HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive you medical records, please inform our office.

Patient Signature: _____ Date: _____

Guardian Signature Authorizing Care: _____ Date: _____