Port City Chiropractic, PC
Dr. Edward J. Galvin, Jr.

PERSONAL INFORMATION

[Age: Birth – 17 years]

Patient Name:_____ Age:_____ Date of Birth: ___/___/___

Mothers Name: _____ Fathers Name: _____

Address:_____
Street/Road City State Zip

Sex: ☐M ☐F Preferred Language: ☐ English ☐ Other:_____

Home Phone #:_____ Cell Phone #:_____

Would you like appointment reminders via text?: ☐Y ☐N If Yes, Cell Phone Carrier:_____

E-Mail Address:_____
We use e-mail for appointment reminders, periodic office updates and monthly wellness information

Race: ☐ Caucasian / White ☐ Hispanic or Latino ☐ African American ☐ American Indian ☐Multi-Raced
☐ Native Hawaiian or Pacific Islander ☐ Other:_____

In Case Of Emergency, Contact:_____ Phone #:_____

Emergency Contact's Relationship to You:_____

Name of Primary Care Physician:_____ Last Seen:_____

How Were You Referred To Our Office (*For New Patients*):_____

CERTIFICATION

1. *I hereby state that all of the above information is complete and truthful.* ***2.*** *I have been advised of my financial responsibility and I fully understand and agree that all fees incurred in this office, regardless of my insurance coverage, are my responsibility.*
3. *If my insurance company requests information in order to process a claim that I have sent to them for processing/payment, I give my permission for such information to be released to the insurance company.*

_____ _____
SIGNATURE OF PATIENT / PARENT / GUARDIAN DATE

Consent for treatment of a minor: (under 18 years of age) *I hereby authorize the doctor to treat* _____ *as they deem appropriate through the use of chiropractic health care.*

_____ _____
SIGNATURE OF PARENT / GUARDIAN DATE

Case History

[Age: 3 – 17 years]

Patient Name:_____ **Sex:** ☐M☐F **Age:**_____ **Date of Birth:**_____

Height: _____ **Weight:** _____

Reason for Today's Visit:_____

_____

When Did Onset Occur? _____

Has your child had previous Chiropractic care? ☐ No ☐Yes List:_____

Please check any symptoms your child is currently experiencing:

☐Headache ☐Neck Pain ☐Mid-Back Pain ☐Low Back Pain

Pain in: ☐Shoulder R / L / B ☐ Elbow R / L / B ☐Wrist R / L / B ☐Hand R / L / B

Pain in: ☐Hip R / L / B ☐Knee R / L / B ☐Ankle R / L / B ☐Foot R / L / B

☐Muscle Aches ☐Stomach Aches ☐Ear Aches ☐Bed Wetting ☐Constipation ☐Diarrhea ☐Asthma ☐Allergies

☐Frequent Colds ☐Sinus Issues

Has your child ever been diagnosed with Scoliosis (curvature of spine)? ☐No ☐Yes

Has your child ever had an ear infection? ☐No ☐Yes If Yes, ☐Right Ear ☐Left Ear ☐Both Ears
Does your child have asthma? ☐No ☐Yes
Are there any smokers in the home? ☐No ☐Yes
Does your child have any skin rashes? ☐No ☐Yes List:_____
Does your child take any medications currently? ☐No ☐Yes List:_____
Does your child have any drug allergies? ☐No ☐Yes List:_____
Does your child take any vitamin supplements? ☐No ☐Yes List:_____
Does your child have any other allergies? ☐No ☐Yes List:_____

Has your child ever had any of the following?

Fractures	☐No	☐Yes	List:_____
Dislocations	☐No	☐Yes	List:_____
Spine Injuries	☐No	☐Yes	List:_____
Car Accidents	☐No	☐Yes	List:_____
Falls/Trauma	☐No	☐Yes	List:_____
Surgeries	☐No	☐Yes	List:_____
Concussion	☐No	☐Yes	List:_____

Does your child wear a helmet when riding a bike, skate board, ice skating or skiing? ☐Yes ☐No

Please list all significant illnesses? ☐None List:_____

_____

Do you have other concerns about your child's health? ☐No ☐Yes Explain:_____

_____

_____

I hereby state that all of the above information is complete and truthful.

_____ _____

SIGNATURE OF PARENT / GUARDIAN **DATE**

Port City Chiropractic, PC

Dr. Edward J. Galvin, Jr.
335 West 1st St.
Oswego, NY 13126
315-342-6151

Authorization for Release of Information & Notice of Privacy Practices

Patient's Name:_____ **Date of Birth:**_____

- I authorize Port City Chiropractic, PC (PCC) to release protected health information, if necessary, about the above-named patient to the people named below.
- I understand that PCC may need to discuss my medical condition and may need to share my medical records with any physician, family member, or other health care provider who is involved in my care.
- PCC may leave messages (for appointment reminders, lab, x-ray, or other test results) on my telephone answering machine at my:

Home #:_____ ☐Y ☐N ***Cell#:***_____ ☐Y ☐N

Work#:_____ ☐Y ☐N

Please make sure we have <u>all</u> of your updated phone numbers

- If necessary, PCC may talk with my spouse/significant other, parents, family member, or my caretaker about my medical condition (for appointment reminders, lab, x-ray, or other test results) and / or billing information. Please list these people below.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

- I was notified that a copy of the PCC ***Patient Privacy Notice*** is available for review in the office or I am able to receive a copy by mail/e-mail if requested.
- I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification. I understand that any change in this authorization is effective from the date signed going forward.
- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

_____

Signature (Patient/Parent/Guardian) Date