

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: Birth – 2 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: _____

Birth History:

Were there any difficulties during the pregnancy? ☐ No ☐ Yes Explain: _____

Delivery History: ☐ Natural ☐ C-Section ☐ Suction ☐ Forceps

How long was the labor? _____ hrs _____ days

Was labor induced? ☐ No ☐ Yes

INFANTS ONLY:

How many hours does your child typically sleep between feedings: During the day: _____ At night: _____

Is your child being breast fed? ☐ Yes ☐ No If No, how long did they breast feed for? _____ Months ☐ Never

If formula fed, which formula or other milk source is used? _____

Does your child frequently spit up after feedings? ☐ No ☐ Yes

Does your child have a lot of intestinal gas? ☐ No ☐ Yes

Does your child cry a lot? ☐ No ☐ Yes

Does your child have normal bowel movements? ☐ Yes ☐ No Explain: _____

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: _____

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



Dr. Edward J. Galvin, Jr.
11 Fourth Avenue
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 all 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