PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your driver's license and all available insurance cards. PLEASE PRINT.

Patient's Name __________________________ Parent's Name: __________________________________

Home Phone ___________________ Cell Phone ___________________ Cell Carrier:________________

Address _______________________________ City ______________________ State _____ ZIP ________

Patient's Age: _____ Birth Date: ___________ Gender: M F Parent's Birth Date: ______________

Email _____________________________ SS#__________________ Driver's License #________________

Parent Employer __________________________ Employer Address _______________________________
City ________________________ State ____ ZIP _______

Work Phone _________________ Do you have health insurance at work? Yes No

Insurance Company _____________________________ Plan/Group #______________ Cert #__________

How did you hear about our office? ☐ Google ☐ Facebook ☐ Friend/Family__________________

☐ Doctor ☐ Event ☐ Other _______________

Reason for your visit today? (Please list areas of pain and symptoms): ____________________________

____

When did the condition begin?____

How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is the condition: ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

What makes the problem worse? __________________ What makes it better? ______________

Emergency Contact & Relationship: _______________________________Phone Number:_____________

Is your condition due to an accident? ☐ Yes ☐ No Date of your Accident: _____________________

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co- payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and the staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. The payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature ____ Date ______________________

Spouse's or Guardian's Signature _______________________________ Date ______________________

Patient Name: ______________________________ Date of Birth: _________________________

PREMIER CHIROPRACTIC & WELLNESS

Please indicate if your child has or ever had any of the following:

Back or Neck Pain	Y	N	Has frequent colds, cough, or runny nose	Y	N
Pain in legs or arms	Y	N	Ear Infections	Y	N
Torticollis (severe head tilt)	Y	N	Tubes in Ears	Y	N
Headaches	Y	N	Had colic as an infant	Y	N
Asthma	Y	N	Eating/Breastfeeing Difficulties	Y	N
Childhood Diseases	Y	N	Constipation	Y	N
Bed Wetting	Y	N	Diarrhea	Y	N
Skin Problems (eczema, rashes, etc)	Y	N	Upset Stomach/Excessive Gas	Y	N

**If child does have allergies, please list below:*

____

____

Trauma

Fall down the stairs	Y	N	Planned C-Section	Y	N
Fall from significant height	Y	N	Injuries (bone fracture, cut, burn, etc)	Y	N
Fall from bicycle, scooter, skate board, etc	Y	N	Motor Vehicle Accident Y N Injuries (bone fracture, burn, cut, etc)	Y	N
Trips and falls easily	Y	N		Y	N

Emotional Status

Please check if your child has or ever had any of the following:

Sleeping Difficulties	Y	N	Cries a lot	Y	N
Has frequent temper tantrums	Y	N	Afraid of new environment	Y	N
Separation Anxiety	Y	N	Shy	Y	N

Family History

Does anyone in the child's family have:

Asthma	Y	N	Food Allergies	Y	N
Respiratory Allergies	Y	N	Takes Vitamin Supplements	Y	N

Patient Name: ________________________________ Date of Birth: __________________________

PREMIER CHIROPRACTIC & WELLNESS

Nutrition:

Please check if your child has received any of the following:

Breast milk: ___________ How Long? ____

Were there or are there any breastfeeding difficulties? _________________________________

Formula (please indicate the brand): ____

Cow's Milk (please indicate the brand): ____

Soy Milk (please indicate the brand): ____

At what age was solid food introduced? _______ What was introduced first? _______________

The child is a good eater	Y N	Has food allergies*	Y N
Likes a variety of foods	Y N	Takes Vitamin Supplements	Y N

**If child does have food allergies, please list below:*

____

____

Which of the following applies the labor and delivery of the child?

☐ Hospital Birth ☐ Home Birth ☐ Planned C-Section ☐ Emergency C-Section

☐ Induced Birth ☐ Forceps ☐ Vacuum Extraction ☐ Epidural

What was the child's head position at brith?

☐ Head Presentation ☐ Breech Presentation ☐ Face Presentation ☐ Unsure

Were any of the following used while pregnant?

☐ Cigarettes ☐ Alcohol ☐ Prescription Mediation: _______________ ☐ No

Did you fall or have a motor vehicle accident while pregnant?
☐ Yes ☐ No

How many weeks pregnant was the mother at the time of delivery? ______________________
At what age did the child start to sit up? _______________ ☐ Not Applicable

At what age did your child start crawling? _______________ ☐ Not Applicable

At what age did your child start to walk? _______________ ☐ Not Applicable

Is your child under medical care for a specific condition? If so, please list the condition and care received. ____

Do you have any concern about your child's health? ____________________________________

Patient Name: ______________________________ Date of Birth: _________________________

Immunization Status:

Choosing not to immunize ____ All up to date and current ____

Name of Pediatrician: ________________________________

Date of Last Exam: ___________________________________

Informed Consent Chiropractic Care

In coming to Premier Chiropractic & Wellness, you give the doctor permission and authority to care for you, the patient, in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The Premier Chiropractic & Wellness doctors, of course, will not give any treatment or health care if they are aware that such care may be contra-indicated.

Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor. Premier Chiropractic & Wellness provides specialized, non-duplicating health care service. The Premier Chiropractic & Wellness doctors are licensed in chiropractic and are available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient at Premier Chiropractic & Wellness, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Initial __________

Photo/Announcement Release:

I, Patient Name (please print) _________________________, give Premier Chiropractic & Wellness permission to use my name and picture in its patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Initial __________

Email/Text Appointment Reminders

We try to utilize the most advanced and convenient way to remind you of your appointments. We offer email or text reminders with 24 hour prior notice. Please provide us with your cell phone and carrier to provide text alerts or email address to provide email alerts, or both. You may also opt out of this service by checking below.

Cell Phone Number & Carrier: _______________________________________

Email Address: _________________________________ Opt out here: ____

Patient Name: ______________________________ Date of Birth: _________________________