Main Street Chiropractic

Confidential Pediatric History form

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help serve you better, please complete the following information. We look forward to working with you! Thank you!

Date: _____ Referred By: _____

Patient Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Sex: _____ Weight: _____ Height: _____ S.S.#: _____

Names of Parents/ Guardians: _____

Purpose for contacting us? _____

Other doctors seen for this condition: N/Y If yes, list doctor's name and prior treatments: _____

_____

Other health problems? _____

Check any of the following conditions your child has suffered from during the past six months:

- ❑ Ear infections
- ❑ Asthma/ Allergies
- ❑ Colic
- ❑ Scoliosis
- ❑ Digestive problems
- ❑ Bed wetting
- ❑ Seizures
- ❑ ADHD
- ❑ Auto accident
- ❑ Chronic colds
- ❑ Recurring fevers
- ❑ Temper tantrums
- ❑ Headaches
- ❑ Growing/ Back pains
- ❑ Other _____

Family History: _____

Previous chiropractor: _____ Date of last visit: _____ Reason: _____

Were you satisfied: _____ Why? _____

Name of pediatrician: _____ Date of last visit: _____ Reason: _____

Were you satisfied? _____ Why? _____

Number of doses of antibiotics your child has taken:

a) During the past six months: _____

b) Total during his/ her life: _____

Number of doses of other prescription medications your child has taken:

a) During the past six months: _____

b) Total during his/ her life: _____

Vaccination history: _____

Feeding History:

Breast Fed: N/Y If yes, how long? _____ Formula: N/Y If yes, how long? _____

Introduced to solids at __ months. Cows' milk at _____ months.

Food/ juice allergies or tolerances: N/Y If yes, please list: _____

Prenatal History:

Name of obstetrician/ midwife: _____

Complications during pregnancy? N/Y If yes, please list them: _____

Ultrasounds during pregnancy? N/Y If yes, how many: _____

Medications during pregnancy/ delivery? N/Y If yes, please list them: _____

Cigarette/ alcohol use during pregnancy? N/Y

Location of birth: Birthing center: _____ Hospital: _____ Home: _____ Other: _____

Birth intervention: Forceps: ___ Vacuum Extraction: ___ Caesarian Section: ___ Emergency or Planned?

Complications during delivery? N Y If yes, please list them: _____

Generic disorders or disabilities? N Y If yes, please list them: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Childhood diseases:

Chicken Pox: N/Y age: ___ Rubeola: N/Y age: ___ Whooping Cough: N/Y age: ___

Rubella: N/Y age: ___ Mumps: N/Y age: ___ Other: _____ N/Y age: ___

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to sound: _____
Respond to visual stimuli: _____
Hold head up: _____
Sit up: _____

Cross Crawl: _____
Stand Alone: _____
Walk Alone: _____

According to the national safety council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? N/Y

Is/ has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). N/Y If yes, please list: _____

_____

Has your child ever been involved in a car accident? N/Y If yes, please list: _____

Has your child been seen on an emergency basis? N/Y If yes, please list: _____

Other traumas not described above? N/Y If yes, please list: _____

Prior surgery? N/Y If yes, please list: _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

I hereby authorize Main Street Chiropractic to administer care to my son/ daughter, as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Relationship to patient: _____

MAIN STREET CHIROPRACTIC

TERMS OF ACCEPTANCE

INFORMED CONSENT

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Main Street Chiropractic, PC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

OFFICE POLICIES

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

FEMALES ONLY:X-RAYS/IMAGING STUDIES

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on _____(date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant. By my signature below, I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to o have the diagnostic x-ray examination the doctor has deemed necessary in my case.

FINANCIAL POLICY

INSURANCE PLANS

For our patients with insurance benefits, please note that although we are happy to bill your insurance carrier as a courtesy, the insurance contract exists between the carrier and the insured. We will accept insurance assignment, but cannot guarantee payment of benefits. **Any questions regarding your benefits should be directed to your insurance carrier directly.**

PAYMENT

Payment is due in full at each appointment for chiropractic services provided. We accept Visa, MasterCard, American Express, Discover, Cash, and Personal Checks. As a courtesy to patients with chiropractic insurance, we electronically submit insurance claims. Payment is due at the time of service for all estimated portions of charges, deductible, co-pay amounts, and non-covered services. If your insurance company has not paid within 45 days, your balance is due in full.

A statement of services rendered will be mailed at the end of each month. Receipt of payment is expected within 30 days from the time of service for any outstanding balance. Your account will be considered delinquent if payment is not received within 60 days from the time of service; a late fee of 1.5% per month will be assessed and will appear on any subsequent statements. Delinquent accounts will be sent to a collection agency, and collections fees will be added to your account. If the balance is deemed uncollectible by the collection agency after 30 days, a report will be filed with the national credit reporting agencies, which will adversely affect your credit rating.

PRIVACY PRACTICES

HIPAA

I have received a copy of Main Street Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

I, _____ have read and fully understand the above statements.

_____

Patient's Signature Date

JDD,DC 5/2011