Explore Family Chiropractic

PEDIATRIC INTAKE FORM

Date: _____

PERSONAL INFORMATION

Child's First Name:_____ M.I.: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Address:_____

City / State / Zip: _____

Birth Date: _____ Age:_____ Sex: M F

# of Siblings: _____

Sibling's Names & Ages: _____

Parent's Names: _____

Best Contact Name: _____ Phone: ( ) _____

Alternate Contact Name:_____ Phone: ( ) _____

Text Reminders: Y N Before Appointment: 1 hr 4 hrs 1 day

Email: _____ *(For updates on office hours, events, etc.)*

Who can we thank for referring you or how did you hear about Explore? _____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Explore Family Chiropractic? _____

_____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST impartant in your child;s life? (List all that apply)

_____

Has your child seen any other providers for this condition? (List all that apply)

_____

Has your child seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What health goal, if your child were to complete or accomplish it, would have the greatest impact on his or her life?

_____

_____

_____

HEALTH CONCERNS

☐ Anxiety/Depression
☐ Constipation/Diarrhea
☐ Nausea/Vomiting
☐ Diabetes
☐ Bed Wetting
☐ Overweight
☐ Frequent Sickness
☐ ADD/ADHD
☐ Detachment/Distant
☐ Irritability/Nervous
☐ Developmental Delay
☐ Fatigue/Sleep Issues
☐ Asthma/Chronic Bronchitis
☐ Colic/Acid Reflux
☐ Back/Neck Pain/Stiffness
☐ Difficulty Gaining Weight
☐ Ear or Other Infections
☐ Headaches
☐ Learning Disorders
☐ Sinus Troubles/Allergies
☐ Autism/Asperger's/Sensory Issues
☐ Other _____
☐ Other _____

Explain any boxes checked above:

_____

_____

Is there anything else regarding your child's current condition you feel the doctor should know? _____

_____

_____

MEDICATIONS

☐ Anxiety/Depression
☐ Asthma
☐ Pain Narcotics
☐ Antibiotics
☐ Migraine/Headache
☐ Acid Reflux
☐ ADD/ADHD
☐ Digestive
☐ Other _____
☐ Other _____
☐ Other _____

Explain any boxes checked above:_____

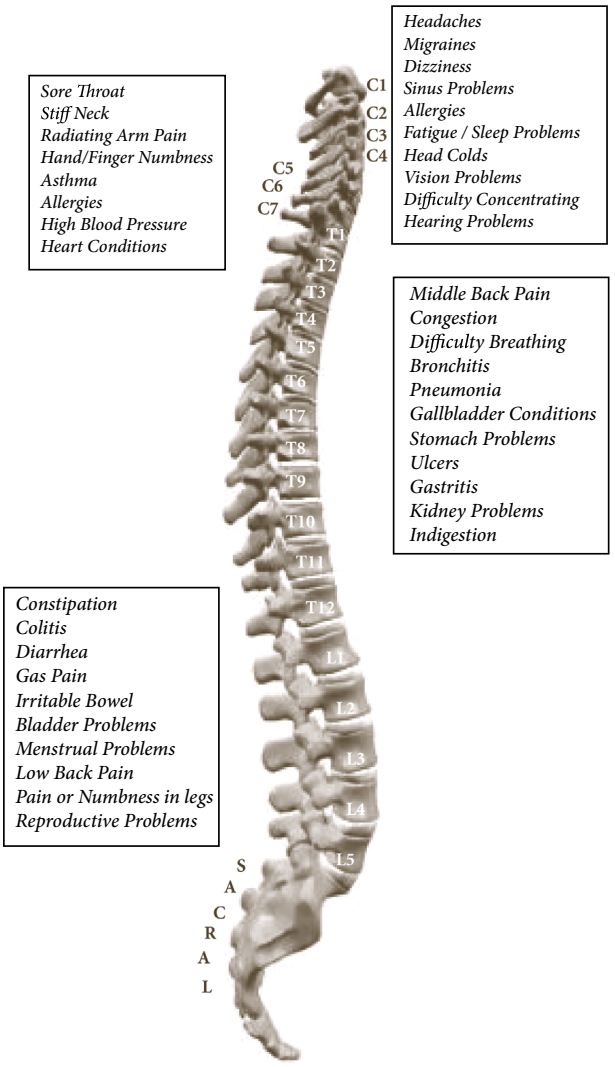
_____

VITAMINS / SUPPLEMENTS

☐ Multi-Vitamin
☐ Vitamin D3
☐ Fish Oil/Omega-3
☐ Probiotics
☐ Other_____
☐ Other_____
☐ Other_____

Did You Know...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



PRENATAL HISTORY

Location of birth: Home Birthing Center Hospital Other: _____

Did any of the following happen during delivery:

☐ C-section delivery ☐ Doctor pulled or twisted baby ☐ Anesthesia ☐ Labor was induced

☐ Forceps/vacuum extraction ☐ Premature delivery ☐ Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery:

_____

During pregnancy, did you experience any illness, complications and/or concerns? If yes, please explain:

_____

Birth weight: _____ Birth length: _____ APGAR scores (if remembered): _____

Ultrasound used during pregnancy? Yes No Number of times: _____

Did /do you breastfeed the baby? Yes No If yes, how long: _____

Did/do you formula-feed the baby? Yes No If yes, how long: _____

At what age did you introduce: Solids:_____ Cow's milk: _____

LIFESTYLE HABITS

Does your child.....

Exercise daily? Yes No How much? _____

Have a positive self-esteem or self-image? Yes No

Play video games or watch TV for more than one hour per day? Yes No How much? _____

Eat balanced meals? Yes No

Experience prolonged sadness? Yes No Explain:_____

Have difficulty sleeping? Yes No Explain: _____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Yes No Explain: _____

Has your child ever been hospitalized or had surgery? Yes No Explain:_____

Does your child have difficulty interacting with others? Yes No Explain:_____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No Explain: _____

_____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Yes No

Please list: _____

Are you aware of any food allergies or intolerance? Yes No Explain: _____

Has your child received all recommended vaccinations? Yes No Explain: _____

Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Explore Family Chiropractic permission to examine, x-ray (if necessary), and treat _____.

Minor date of birth: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____

For Office Use Only

ID#: _____ Films: _____ ROF:_____

V:_____ P:_____ A: _____

Other _____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcments, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature:_____ Relationship to Patient:_____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctors' recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Explore Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement charges incurred by me.
- Chiropractic care in this office deals with vertebral subluxation, and will therefore be billed under the S8990 adjustment code. While we will provide an itemized receipt upon your request, we anticipate that care will not be reimbursed by a third party carrier. This does not apply to PI, WSI, or Medicare. HSA and FLEX spending accounts may be utilized.
- I authorize the direct payment to Explore Family Chiripractic of any sum I now or hereafter owe by my attorney out of settlement of my case and by any insurance company obligated to make payment to me or Explore Family Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Explore Family Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered on behalf of the undersigned by Explore Family Chiropractic.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN)*. Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.

Date: _____ Parent/Guardian Signature : _____

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at Explore to treat my child's condition as deemed appropriate. At Explore Family Chiropractic we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any staff member of Explore Family Chiropractic responsible for any errors or omissions that I may have made in the completion this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your child's care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Parent/Guardian Signature : _____

Advanced Beneficiary Notice (ABN)

The purpose of this form is to help you be aware of chiropractic services in this office as it relates to any medical insurance you may have. Chiropractic care in this office is not focused on diagnosis of or relief of symptoms; it is centered on the location, analysis, and correction of underlying vertebral subluxations. Because of this, all services are coded in a manner which insurance carriers view as maintenance or wellness care and most likely will not be covered. Signing below signifies that you want the services provided in this office, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion and policies as it relates to insurance coverage, not an official Medicare or other insurance carrier's stance or decision. Signing below indicates you have received and understand this notice.

Date: _____

Name (Printed): _____

Signature: _____

Parent/Guardian Signature (if applicable) _____