PEDIATRIC NEW PATIENT INFORMATION

Date: _____

PATIENT INFORMATION

Child's Name: _____ Child's Nickname: _____

Reason for visit: _____

Sex: M / F Date of Birth: _____ Age: _____

Child's Home Phone #: _____

Child's Home Address: _____

Who may we thank for referring you? _____

FAMILY INFORMATION

Mother's name: _____ Partner's name: _____

Home phone #: _____ Home phone #: _____

Work phone #: _____ Work phone #: _____

Email: _____

Please email me: Monthly Statement ___ Monthly Newsletters ___

Parent's Marital Status: Married ___ Single ___ Divorced ___ Widowed ___

List Ages of Other Children in Family: _____

Predominant language used at home: _____

PAYMENT INFORMATION

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Policy Holder's Name: _____ Policy Holder's Birth Date: _____

Insurance Company Name: _____ Patient's ID #: _____

Policy Holder's Employer: _____ Group #: _____

CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _____as the examining / treating doctor deems necessary.
I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name: _____ Signature: _____

Date: _____ Witnessed by: _____

School Age Child History

6 years and older

Today's Date _____

Name _____ Sex: M F DOB _____ Age _____

Reason for Today's Visit _____

When did this problem first occur? _____

Circle

Yes No Have you ever had this problem before? _____

Yes No Have you previously been treated for this problem? Doctors Name _____

Yes No Have you previously been to a chiropractor? When? _____

About Your Health

In the past year have you had any of the following:

Yes No Back or Neck pain? _____

Yes No Pain in the legs or arms? _____

Yes No Headaches? _____

Yes No Asthma? _____

Yes No Allergies? _____

Yes No Earaches? _____

Yes No Falls from a bicycle, skateboard, scooter, rollerblades or similar? _____

Yes No Do you ever have a problem of bedwetting? _____

Yes No Have you ever been in a motor vehicle accident? _____

Yes No Have you ever had any broken bones? _____

Yes No Have you ever had any surgeries? _____

Yes No Are you, at present, taking any medications? _____

Yes No Do you have any other health problems? _____

_____

School-Age Child History
6 years and Older

About your Lifestyle

What grade are you in at school? _____

How do you carry your schoolbooks? _____

How heavy is your school book bag? _____

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch T.V? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On Average, on how many hours sleep do you get each night? _____

Are there any smokers in your family? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you have blurred vision? _____

Do you wear glasses or contact lenses? _____

Do you sometimes get headaches when you read? _____

About your Diet

What do you usually eat for Breakfast? _____
_____

What do you usually eat for Lunch? _____
_____

What do you usually eat for Dinner? _____
_____

What snacks do you have after school? _____

What is your favorite food? _____

How much water do you drink each day? _____

How much sodas or colas do you drink each day? _____

How often do you eat fast food items? _____

8120 Penn Ave S., Suite 245
Bloomington, MN 55431

PATIENT CONSENT FORM

Patient Name: _____
(Please Print)

Date of Birth: _____

I, the patient above, or guardian for the patient, voluntarily consent to such care encompassing diagnostic procedures and medical treatment provided by the chiropractic physician as is necessary in his/her professional judgment. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of
examination or treatment in this facility.

_____ I hereby authorize Child and Family Chiropractic Center to release medical information regarding myself and my current condition to my insurance company for purposes of payment and /or quality reviews; and to referring, consulting treating physicians, or other medical providers as necessary to support continuation of care.

_____ I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. **I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage**. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

_____ I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand that if I want a more detailed account of how my Patient Health Information is going to be used in this office and my rights concerning those records, I can request and obtain a copy of the HIPAA NOTICE that is available at the front desk. I understand that if there is anyone that I do not want to receive my medical records, I will inform the office.

I have read this form and understand its contents at this date and time.

_____ _____ _____
PATIENT OR LEGAL REPRESENTATIVE **LEGAL RELATIONSHIP** **DATE**

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic manipulations or adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

Patient Signature: _____

Date: _____

To be completed by the patient's representative, if necessary, e.g., if patient is a minor or physically or otherwise legally incapacitated.

Signature of Patient's Representative: _____

Date: _____

Child and Family Chiropractic Center, LLC

Dr. Felicia M Conner, DC, DICCP