PEDIATRIC HISTORY FORM

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients! To help us serve you best, please provide us with the following information. We look forward to working with you to build better health and wellness for your family.

PATIENT INFORMATION

Name: _____ Birth Date: ____ /____ /_____ Today's Date: _____
Sex: _____ Height: _____ Weight: _____ Social Security #_____

Name(s) of parent(s)/guardian(s)_____
Address: _____ City: _____ State_____ Zip: _____
Home phone: _____ Work phone: _____ Email: _____
Would you like to receive periodic health articles? Y or N Referred by: _____
Siblings: _____

HEALTH HISTORY

Purpose for contacting us? _____
_____
_____
Have other doctors been seen for this condition? Y or N
Doctor's names and prior treatments: _____
_____
Other health concerns? _____
Circle any of the following conditions your child has suffered from in the past six months:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma/Allergies	Digestive Problems	ADHD	Recurring Fevers	Growing/Back Pains
Colic	Bed Wetting	Car Accident	Temper Tantrums	Acid Reflux

Others: _____
Previous Chiropractor: _____ Frequency of visits: _____
Date of last visit: _____ Reason: _____
Name of Pediatrician: _____ Frequency of visits: _____
Date of last visit: _____ Reason: _____

MEDICATIONS

Current medications and dosage: _____
Other medications taken in the past six months: _____
Number of rounds of antibiotics your child has taken in the past six months: _____During lifetime: _____
Vaccination history: _____
Any reactions? _____
Have you withheld any vaccines? Y or N Why? _____
_____

PRENATAL HISTORY

Name of obstetrician/midwife: _____
Complications during pregnancy? Y or N Describe: _____
Ultrasounds during pregnancy? Y or N Number? _____ Medications during delivery? Y or N
Cigarette use during pregnancy? Y or N Alcohol use during pregnancy? Y or N
Location of birth:

_____
Delivery method (circle): Vaginal Cesarean Section Emergency Planned Other: _____
Complications during delivery? Y or N Describe: _____
Birth Intervention (circle): Forceps Vacuum Extraction
Birth weight: _____ Birth Length: _____ APGAR Scores: _____

FEEDING HISTORY

Breast fed? Y or N How long? _____ Formula fed? Y or N How long? _____ Type: _____
Introduced solids at_____ months. Cow's milk at _____ months. Food/juice allergies or intolerances? Y or N
List: _____

DEVELOPMENTAL HISTORY

During infancy and early childhood, development of 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). To help us better understand how your child's spine is developing, please answer the following:

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? Y or N

ACTIVITY HISTORY

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y or N List: _____
_____
Do you own a trampoline? Y or N
Has your child ever been involved in a car accident? Y or N Describe: _____
_____
Has your child ever been seen at an ER or Urgent Treatment Facility? Y or N Describe: _____
_____
Other traumas not described above? Y or N Describe: _____
_____
Prior Surgery? Y or N Describe: _____
_____

We are here to serve you and we encourage you to ask questions.
Your participation is vital and will help determine your results.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors 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.
Print name: _____ Signature: _____ Date: _____
Witnessed: _____

PROFESSIONAL FEE SCHEDULE

INITIAL VISIT AND STANDARD VISITS

Consultation	No charge
Examination	$60-140
X-rays (per view)	$55
Office visit/adjustment	$30-55
Extremity Adjustment	$55
Therapies	$35

Our experience has shown that it is wise to have an understanding with our patients as to our policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being, and we will do our best to help you in any way we can.

PLAN 1: Group Insurance

If you have insurance which covers chiropractic are, we will bill your insurance directly. Please present your insurance card on your first visit. Until we have the completed necessary information to verify coverage, you will be required to pay for your care. This includes any deductible or co-pay at the time of your service. In the event the insurance check should come to you, you are expected to bring the check in to us. Remember, insurance companies do not guarantee payment, do not pay for maintenance care, and ordinarily are designed and intended to only take care of acute problems. Please understand that insurance companies have cost containment programs to reduce the number of claims paid even when the patient's care is justified.

PLAN 2: Cash

Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

PLAN 3: Health Care Made Affordable (HCMA)

For those patients who qualify, we offer discounted cash agreements on a monthly and block basis. Please ask for details.

PLAN 4: Auto/Personal Injury

You may need to report the accident and present your auto insurance card to us on your first visit. Payment will be required until your coverage can be verified. We will bill the insurance company directly.

Insurance verification and authorization is not a guarantee of payment and I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Finish Line Chiropractic to release any information regarding my treatment to any insurance company in the effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

I have read and understand all of the options available to me.

Signature: _____ Parent/Guardian signature (if minor): _____

Date: _____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care treatment we must require you to read and sign this consent form stating that you understand and agree with how your record will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this office to submit required PHI to the Health Insurance Company (or companies) provided to use by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and rights privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designed to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

Printed name: _____ Signature: _____Date: _____