ALIGNED CHIROPRACTIC

Pediatric New Patient Paperwork

Child's Name: _____ Age: _____ DOB : _____ Sex: M F

Street Address: _____ City, State, Zip: _____

Parent's Names: _____

Phone Number: _____ Email: _____

Reason for coming to our office: _____

How did you hear about us?:

- Physician - Family or Friend (name) _____
- Insurance - Internet - Other (please specify) _____

Name of Person Responsible for the Account: _____

Relationship to the Patient: _____

Address (if different than above): _____ City, State, Zip: _____

Insurance Company: _____ Name of Policy Holder: _____

Policy Holder DOB: _____ Relationship to the Patient: _____

*********CONSENT FOR TREATMENT OF MINOR: PLEASE READ AND SIGN! *********

I hereby certify that the information I have provided is correct and accurate, to the best of my knowledge.

I, _____, as the parent/guardian of this child, _____, hereby grant permission for my child to receive an examination and chiropractic treatment as deemed necessary.

Signature of Parent or Guardian: _____ Date: _____

Current Health Condition(s):

Reasons for today's visit:

1. _____
2. _____
3. _____

Have you consulted with any other health care practitioner for the complaint? Y N

- If yes, who?

_____

- Did they have a recommendation for treatment? (ex. Medication, referral, etc) Y N
- If yes, please explain

_____

Name of Pediatrician: _____

Current Medications and/or Vitamins:

1. _____
2. _____
3. _____
4. _____

Past Trauma (falls, accidents, injuries, etc) and Approximate Date of Trauma:

1. _____
2. _____
3. _____
4. _____

Past Surgeries and Approximate Date of Surgeries:

1. _____
2. _____
3. _____
4. _____

Past Hospitalizations/Illnesses and Approximate Date:

1. _____
2. _____
3. _____
4. _____

Has the child been vaccinated?: Y N

Please indicate any current or past problems your child has on the list below:

__ Anemia
__Arthritis
__ADHD
__Allergies
__ Anxiety
__ Arm/Elbow Pain
__ Asthma
__ Autism
__ Backaches
__ Behavioral Issues
__ Bed Wetting
__ Blood Disorders
__ Broken Bones
__ Chest Pain
__ Chronic Earaches
__ Colic
__ Concussions
__ Unusual Moles
__ Constipation
__ Convulsions
__ Cough/Wheeze
__ Diabetes
__ Diarrhea
__ Digestive Problems
__ Dizziness
__ Eczema
__ Fainting
__ Fever/Chills
__ Frequent Colds
__ Growing Pains
__ Headaches
__ Heart Condition
__ Hernias
__ Hyperactivity
__ Hypertension
__ Other: _____
__ Joint Pain
__ Insomnia
__ Itchy Eyes
__ Knee/Foot Pain
__ Leg/Hip Pain
__ Muscle Pain
__ Neck Pain
__ Nightmares
__ Poor Appetite
__ Poor Memory
__ Rashes
__ Reflux/Spitting Up
__ Runny Nose
__ Scoliosis
__ Sinus Trouble
__ Sprains/Strains
__ Stomach Aches

Childhood Diseases (please indicate age if had):

__ Chicken Pox (age: _____)
__ Measles (age: _____)
__ Mumps (age: _____)
__ Rubella (age: _____)
__ Meningitis (age: _____)
__ Tuberculosis (age: _____)
__ Whooping Cough (age: _____)
__ Other (age: _____)

Developmental History:

Sleeping (hours per night): _____

Problems sleeping: _____

Prenatal History:

Location of Birth (please select):

__ Home

__ Birthing Center

__ Hospital

Complications during pregnancy: Y N

- If yes, please explain:

_____

_____

Medications during pregnancy/delivery: _____

Cigarette or Alcohol use during pregnancy: Y N

Birth Intervention (please select if applicable):

__ Forceps

__ Vacuum

__ Caesarian (C-Section)

Complications during delivery: Y N

- If yes, please explain:

_____

_____

Birth weight: _____

Birth length: _____

Feeding History:

Did you breastfeed or use formula? _____

- How long? _____

Please list any food allergies or intolerances:

1. _____
2. _____
3. _____

Financial Policy

Financial Responsibility: I understand that I am ultimately responsible for any unpaid balance or non-covered service and am responsible for all costs of pursuing such balances if I fail to pay. (excluding VA patients **ONLY** within covered visit amounts and any contractual agreements for ALIGNED CHIROPRACTIC PLLC and DR FELICIA CAMPBELL DC)

Referrals/Authorization: I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full is required at the time of service.

This financial policy was signed by:

Printed Name: _____

Signature: _____ Date: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have been advised about our full HIPAA compliance rules, regulations, and advisements notices before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- Patient/Guardian of patient has been advised through this document that full HIPAA compliance rules, regulations, and advisements notices for Aligned Chiropractic PLLC available at patient's request.

This consent was signed by:

Printed Name:_____

Signature:_____ Date: _____

Witness:_____ Date: _____