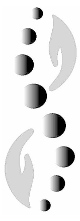

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CHILD
PATIENT INFORMATION

INSURANCE INFORMATION: Please present your insurance card(s) at time of service. If you have primary **AND** secondary insurance please inform the front desk, so there is no discrepancy with your claims.

1 PATIENT DEMOGRAPHICS

CHILD'S FIRST NAME ____ CHILD'S LAST NAME ____

ADDRESS ____

CITY ____ STATE ____ ZIP ____

PHONE ____ FUTURE APPOINTMENT TEXT REMINDERS? ◯ Y ◯ N CELL PHONE PROVIDER ____

EMAIL ____ *This will be used to email receipts, for future newsletter mailings or massage specials only. It will not be solicited.*

BIRTH DATE MM|DD|YYYY ____ GENDER ◯ M ◯ F AGE ____

MOTHER'S NAME ____ PHONE ____ SOCIAL SEC. XXX-XX-XXXX ____

FATHER'S NAME ____ PHONE ____ SOCIAL SEC. XXX-XX-XXXX ____

INSURED'S NAME ____ INSURED'S BIRTH DATE MM|DD|YYYY ____

INSURED'S EMPLOYER ____ OCCUPATION ____

HOW DID YOU HEAR ABOUT OUR OFFICE? ◯ GOOGLE ◯ INSURANCE CARRIER ◯ OTHER

◯ EXISTING PATIENT ____ ◯ ANOTHERPROVIDER ____

2 EMERGENCY CONTACT

FIRST NAME ____ LAST NAME ____

RELATIONSHIP TO YOU ____ PHONE ____

PRIMARY DOCTOR/CLINIC ____ PHONE ____

You may be asked to sign a Patient Authorization to Release Information, as we would want to request information from other providers that have participated in your care. This will help insure that we have all information concerning your condition.

AUTHORIZATION FOR CARE OF MINOR

PARENT/GUARDIAN NAME (PRINT) ____ PARENT/GUARDIAN SIGNATURE ____ DATE ____

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PATIENT NAME (PRINT) ____________________ DATE ____________

NAME OF INSURANCE CARRIER ____________________

POLICY NUMBER ____________________ GROUP NUMBER ____________

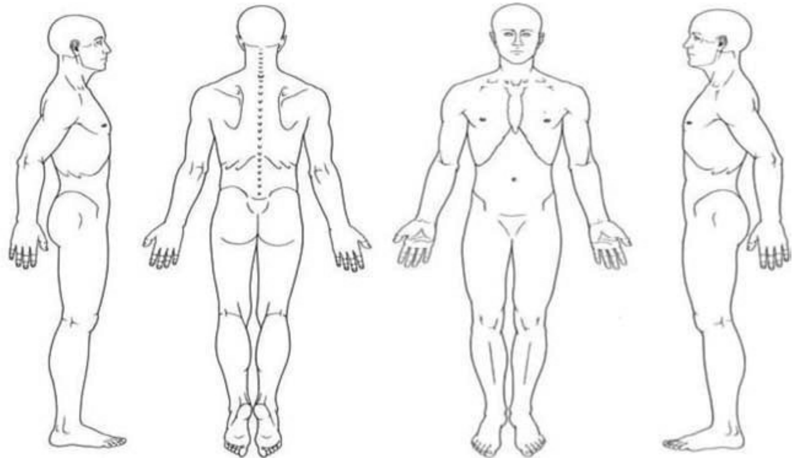
1. **Describe your symptoms** ____________________

When & how did your symptoms start? ____________________

What makes it better/worse? ____________________

2. **How often do you experience your symptoms?**
   - ◯ Constantly (76-100% of the day)
   - ◯ Frequently (51-75% of the day)
   - ◯ Occasionally (26-50% of the day)
   - ◯ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. **What describes the nature of your symptoms?**
   - ◯ Sharp ◯ Shooting
   - ◯ Dull ache ◯ Burning
   - ◯ Numb ◯ Tingling

4. **What describes the nature of your symptoms?**
   - ◯ Getting Better
   - ◯ Not Changing
   - ◯ Getting Worse

5. **During the past 4 weeks:**

   Indicate the average intensity of your symptoms — NONE ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ UNBEARABLE

   How much has pain interfered with your normal schedule? (Including work and home)

   ◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

   How much of the time has your condition interfered with your social activities?

   ◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

6. **In general would you say your overall health is right now.**

   ◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

7. **Who have you seen for your symptoms?** ◯ Chiropractor ◯ Medical Doctor ◯ Physical Therapist ◯ Other

   What treatment did you receive and when? ____________________

   What tests have you had for your symptoms? ◯ Xrays DATE ________ ◯ CT Scan DATE ________ ◯ MRI DATE ________ ◯ Other DATE ________

8. **Have you had similar symptoms in the past?** ◯ Yes ◯ No

   If you have received treatment in the past for the same or similar symptoms, who did you see? ◯ This Office ◯ Medical Doctor ◯ Other ◯ Chiropractor ◯ Physical Therapist

9. Is your pain: ◯ worse in morning ◯ worse at night ◯ worse with cough/sneeze ◯ disrupting sleep

   Have you ever been to a chiropractor before? ◯ Yes ◯ No

   If YES, when was your last adjustment? DATE ____________________

PARENT/GUARDIAN SIGNATURE ____________________ DATE ____________

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PATIENT NAME (PRINT) ______________________ DATE ____________

What type of regular exercise do you perform? ○ None ○ Light ○ Moderate ○ Active

What is your height and weight? Height [FEET | INCHES] Weight [ ] lbs

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past.
If you presently have a condition listed below, place a check in the Present column.

PAST	PRESENT	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular In-coordination
○	○	Visual Disturbances
○	○	Dizziness

PAST	PRESENT	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

PAST	PRESENT	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco
○	○	Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS
		Females Only
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
		Other Health Issues
○	○	____________
○	○	____________
○	○	____________

Indicate if any immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ Other ____________

List all prescriptions, over-the-counter medications, and nutritional supplements you are taking:

____________ ____________ ____________

____________ ____________ ____________

List all surgical procedures and times you have been hospitalized:

____________ ____________ ____________

____________ ____________ ____________

PARENT/GUARDIAN NAME (PRINT) ____________ PARENT/GUARDIAN SIGNATURE ____________ DATE ____________

Doctor's Additional Comments

DOCTOR SIGNATURE ____________ DATE ____________

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PATIENT NAME (PRINT) ______________________ DATE ____________

FINANCIAL POLICY

1. Please verify your chiropractic benefits with your health insurance company. When our staff calls on your benefits they only give us an outline of benefits, not a guarantee of payment. All benefits are subject to the terms and exclusions of your policy.
2. Your insurance will make payments for any authorized and/or covered services. You are required to pay for services and materials that your insurance does not cover.
3. If your insurance requires a referral from another provider, we will require information of the referral to process your insurance with in–network benefits. Until this information is provided to us, we require you to pay all co–pays, deductibles and/or co–insurance relating to out–of–network benefits. Any over payments to your account will be reimbursed to you after insurance pays their portion.
4. If your insurance carrier has not paid your claim within sixty days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid your claim within ninety days of submission, you accept full responsibility for payment of any outstanding balance. If your account becomes delinquent and consequently gets forwarded to a collections agency, you accept full responsibility of all charges.
5. I hereby authorize payment to be made directly to New Beginnings Chiropractic LLC for all benefits which may be payable under a Healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to New Beginnings LLC for any and all services I receive at this office.

I have read and understand and agree to abide by the information stated above as it applies to my coverage.

PARENT/GUARDIAN NAME (PRINT) ______________ PARENT/GUARDIAN SIGNATURE ______________ DATE ____________

INFORMED CONSENT TO CHIROPRACTIC TREATMENT OF A MINOR

I hereby request and consent to the performance of chiropractic procedures, including a comprehensive exam, diagnostic testing, physical therapy techniques, massage or manual therapy, adjustments or manipulation, and acupuncture on me which are recommended by the doctors at New Beginnings Chiropractic, and/or other licensed doctor of chiropractic who now or in the future render treatment to me while employed by or associated with New Beginnings Chiropractic. I have had an opportunity to discuss with the physician and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, muscle sprain/strain, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

AUTHORIZATION FOR CARE OF MINOR

I have read and understand the information stated above. I agree to the recommended treatment of this minor. I intend this consent form to cover the entire course of treatment for the present condition(s) and for any condition(s) for which this minor seeks treatment at this facility.

PARENT/GUARDIAN NAME (PRINT) ______________ PARENT/GUARDIAN SIGNATURE ______________ DATE ____________

I consent to the use or disclosure of my protected health information by New Beginnings Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of New Beginnings Chiropractic. I understand that analysis, diagnosis or treatment of me by New Beginnings Chiropractic may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment or healthcare operations of this practice. New Beginnings Chiropractic is not required to agree to the restrictions that I may request. However, if New Beginnings agrees to a restriction that I request, the restriction is binding on New Beginnings Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that New Beginnings Chiropractic has taken action in reliance on the consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, and health plan, my employer or a health care clearinghouse. This protected health information relates to my past,present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. A full copy of HIPAA policies are available upon request.

PARENT/GUARDIAN NAME (PRINT) ______________ PARENT/GUARDIAN SIGNATURE ______________ DATE ____________