newbeginnings chiropractic

PEDIATRIC
PATIENT INFORMATION

PERSONAL INFORMATION

Date_____

Child's Name:_____ Address_____

Gender ❑ M ❑ F Age_____ Birthdate_____ _____
City State Zip

Child's SS#_____ Home #_____ Mobile #_____

Mother's Name _____ Father's Name _____

Phone (H)_____ (W)_____ Phone (H)_____ (W)_____

Employer _____ Employer _____

May we send you our office newsletters? ❑ Yes ❑ No Whom may we thank for referring you?_____

BIRTH INFORMATION

We believe that it is never too early to get involved in maintaining optimal health. Problems with the spine and nervous system can begin with the birth process or very early in life, so it is important to have our nervous systems checked regularly.

What was your child's birth like?_____

How long was the entire labor?_____ How long did the mother actually push?_____

Has this child been immunized? ❑ Yes ❑ No If yes, when and for what?_____

Did mom have any health concerns during pregnancy?_____

Child's birth weight _____ Did this child go full term? ❑ Yes ❑ No Delivery: Vaginal ☐ C-Section ☐

Was labor induced: ❑ Yes ❑ No Was this child breast fed? ❑ Yes ❑ No How long? _____

HEALTH HISTORY

Please mark "Yes" or "No" to indicate if your child has had any of the following:

Sugery:	❑ Yes ❑ No	Ear infections:	❑ Yes ❑ No	Pneumonia:	❑ Yes ❑ No
Sore Throat:	❑ Yes ❑ No	Hepatitis:	❑ Yes ❑ No	Seizures:	❑ Yes ❑ No
HIV/AIDS	❑ Yes ❑ No	ADD/ADHD	❑ Yes ❑ No	Measles:	❑ Yes ❑ No
Mumps:	❑ Yes ❑ No	Asthma:	❑ Yes ❑ No	Chicken Pox:	❑ Yes ❑ No
Allergies:	❑ Yes ❑ No	Bed wetting:	❑ Yes ❑ No	Croup:	❑ Yes ❑ No
Heart Conditions:	❑ Yes ❑ No	Digestive Problems:	❑ Yes ❑ No	Lung Problems:	❑ Yes ❑ No
Kidney Problems:	❑ Yes ❑ No	Emotional Problems:	❑ Yes ❑ No	Cancer:	❑ Yes ❑ No
Back Pain:	❑ Yes ❑ No	Headaches:	❑ Yes ❑ No	Other:	❑ Yes ❑ No

What other wellness professionals are currently part of your health care team?

❑ Massage Therapist ❑ Acupuncturist ❑ Naturopath ❑ Homeopath ❑ Other_____

How many Medical Doctor's office visits did your child have last year?

❑ None ❑ Less than 2 ❑ Between 2 and 5 ❑ More than 5

Has this child had previous Chiropractic care? ❑ Yes ❑ No This year? ❑ Yes ❑ No

If yes, with whom_____

List previous surgeries and dates:_____

Medications: ❑ Pain Meds ❑ Heart Meds ❑ Cholesterol Meds ❑ Birth Control ❑ Other_____

There many different types of stresses that can have serious consequences regarding your child's future health. Please indicate whether they have ever experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to their present health concerns.

Repeated/prolonged Antibiotic Use:	❑ Yes ❑ No	Inhaler Use:	❑ Yes ❑ No
Car Accident(s):	❑ Yes ❑ No	Prescription Medication:	❑ Yes ❑ No
Fall/Jump from a height <3 feet:	❑ Yes ❑ No	Surgery:	❑ Yes ❑ No
Fall/Jump from a height >3 feet:	❑ Yes ❑ No	Vaccinations:	❑ Yes ❑ No
Childhood Illness:	❑ Yes ❑ No	Youth Sports:	❑ Yes ❑ No
Head Trauma:	❑ Yes ❑ No	Other Trauma (physical or emotional):	
		_____	

47% of all children fall on their head by the age of one and have at least 200 major major falls by the age of 5 years old. Please answer these questions regarding your child's health.

When was your child's most recent fall? _____

Was any care given? ❑ Yes ❑ No Was s/he checked by a chiropractor? ❑ Yes ❑ No

If this child has been invovled in a motor vehicle addicent as a passenger Briefly describe:_____

Was any care given? ❑ Yes ❑ No Was s/he checked by a chiropractor? ❑ Yes ❑ No

What sports or recreational activities does s/he do?_____

Describe your child's most recent stress, strain, or injury while doing these activities?_____

Was any care given? ❑ Yes ❑ No Was s/he checked by a chiropractor? ❑ Yes ❑ No

FAMILY HEALTH HISTORY

Has any member of your family ever had:

Diabetes?	Y	N	Who?_____	Cancer?	Y	N	Who?_____
Heart Disease?	Y	N	Who?_____	Allergies?	Y	N	Who?_____
Scoliosis?	Y	N	Who?_____	Spinal Sugery?	Y	N	Who?_____
Other?	Y	N	Who?_____				

CURRENT HEALTH CONCERNS

What is the nature of your visit today: ❑ Chiropractic wellness evaluation/no specific concern ❑ Specific health concern

If specific concern, please continue with this section. Describe concern:_____

List other providers seen for this condition:_____

Treatments or recommendations given to date:_____

INSURANCE (if applicable)

Primary: Who is responsible for this account?_____ Relationship: ❑ self ❑ spouse ❑ parent ❑ other_____

Insurance Co._____Group #_____ Subscriber's Name_____

Subscriber's Birthdate_____SS#_____-_____-_____

Additional Insurance ❑ Yes ❑ No Insurance Co._____Group #_____

Subscriber's Name_____ Subscriber's Birthdate_____SS#_____-_____-_____

Relationship: ❑ self ❑ spouse ❑ parent ❑ other_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Joyce Chung Quiros all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Reponsible Party Signature Relationship Date

newbeginnings chiropractic

making your health a priority

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