PEDIATRIC PATIENT INTAKE FORM

Today's Date: _____

Last Name:	**First Name:**	**Middle Initial:**
Mailing Address:	**City:**	**State:** **Zip:**
Date of Birth: Age:	Social Security Number: - -	
Height: Weight:	Who Referred You to Our Office:	
Cell Phone: ( ) -	Parents Names:	
Home Phone: ( ) -		
E-mail Address:	Pediatrician: Naturopath/ Other Providers:	

As a courtesy, we send Appointment Reminders to patients or parents/guardians of our patients 24 hours before any future appointments. Please let us know whether you would prefer to receive these reminders via text message or email.	☐ Text Message. Cell Phone Carrier: _____(required) ☐ E-mail (please be sure to provide your email address above) ☐ I would prefer not to receive appointment reminders.

Emergency Contact: _____ Phone: _____

CONSENT FOR TREATMENT OF A MINOR:

I _____ hereby authorize the providers at Center for Chiropractic & Pain Rehabilitation to administer treatment as they deem necessary for my child. Full name of dependent:_____

Your Name: _____ Relationship to Dependent:_____

HEALTH INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	☐ Yes, ☐ No ☐ Unsure If Yes or Unsure, please allow us to copy your insurance card so that we can verify your insurance benefits.

HIPPA STATEMENT:

As a patient of Center for Chiropractic and Pain Rehabilitation (CCPR), you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the ways in which we secure your information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Notes taken during appointments are kept in your chart and secured in out clinic at all times. If patient charts are in public areas, the names are covered. Access to the clinic is limited to practitioners and employees. Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the clinic setting to protect your privacy and ensure that important information is kept in your chart. Your healthcare information is private and cannot be copied or shared with anyone else without your written signed consent. In some cases, verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax and are accompanied with a confidential patient information cover sheet is faxed. Our office needs to leave messages, return telephone calls, and send office mail to your mailing address as part of our normal practice. Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means.

MISSED APPOINTMENT POLICY:

A 24-hour notice is required for all cancellations. A **$40 fee will be charged for all missed appointments.** This fee will not be covered by your group, auto, or personal insurance. If we are closed, please leave a detailed message.

INFORMED CONSENT FOR CHIROPRACTIC CARE:

As a patient at CCPR, I give the doctor of chiropractic (DC) permission and authority to care for me in accordance with the chiropractic tests, diagnosis and analysis s/he performs. The chiropractic adjustments and other clinic procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The DC will not provide treatment if s/he is aware of any contraindications. It is the responsibility of you the patient to make it known to the DC if you have any latent pathological defects, illnesses or deformities that would not be obvious to the DC. I understand that if I am accepted as a patient by a DC at CCPR, I am authorizing him/her to proceed with any treatment deemed to be necessary. The procedures, alternatives and risks involving the treatment will be explained to me prior to the treatment.

_____ **Parent/Guardian Signature** _____ **Date**	I am the responsible party. I have read and understand my right to privacy, as per the above **HIPPA STATEMENT** and agree to have the practitioners and employees of CCPR maintain my records confidentially in accordance with the law. I agree to the above **MISSED APPOINTMENT** and **INFORMED CONSENT FOR CHIROPRACTIC CARE** policies. I agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my insurance carrier. CCPR expects payment at the conclusion of each treatment for cash paying patients and the co-payment, co-insurance and/or deductible payments for health insurance patients.

PEDIATRIC GENERAL HEALTH HISTORY

REASON FOR TODAY'S VISIT

☐ Wellness Check-up	☐ Infant Examination
☐ Sports Injury	☐ Fussy Baby/ Colic
☐ School/Sports/Camp Physical	☐ Nursing Difficulties
☐ Sleep Difficulties	☐ Ear Pain/ Infection
☐ Birth Trauma	☐ Headaches
☐ Back Pain	☐ Growing Pains
☐ Injury	☐ Other:

Please describe in detail the reason for today's visit

_____

_____

_____

Did your child's symptoms come on? ☐ Suddenly, ☐ Gradually

PATIENT'S HISTORY OF GESTATION & BIRTH:

Any complications during the mother's pregnancy with this patient? If yes, please describe.

_____

Any complications during the labor and delivery? If yes, please describe.

_____

Any complications/concerns following birth? If yes, please describe.

_____

Please check the following boxes if your child currently has or has had any of the following in the past.

☐ Asthma	☐ Torticollis	☐ Nocturnal Enuresis (bedwetting)
☐ Developmental Delays	☐ Autism/Aspergers	☐ Learning Difficulties/Disabilities
☐ Gastric Reflux/ Acid Reflux	☐ Sensory Integration Difficulties	☐ Balance problems
☐ Food Sensitivities	☐ Dermatitis/Rash	☐ Chicken Pox

Is your child taking any medications/supplements? If yes, please list.

_____

_____

Has your child had any fractures/broken bones? If yes, please list.

_____

_____

Has your child had any surgeries? If yes, please list.

_____

_____

Is your child up to date with his/her immunizations?

_____

_____

Has your child had any significant injuries, falls, head bonks, etc? If yes, please describe.

_____

_____

Is there anything else that Dr. Megan should know about your child?

_____

_____

Has your child been to a Chiropractor before for any condition?

☐ No, ☐ Yes If yes, Chiropractor's Name : _____ Year:_____

Problem(s) seen by Chiropractor for: _____

NOTICE OF PRIVACY PRACTICES

We are required by federal and state laws, to maintain the privacy of your health information. We are required to follow the privacy practices as described below. We reserve the right to change this accordance with applicable law. We support your right to the privacy of your health information. You may request a copy of this Notice at any time.

- We may share your health information with a physician or other healthcare provider treating you.
- We may use your health information to obtain payment for services from your insurance company.
- You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Without your written authorization, we cannot use or disclose your health information for any reason except hose permitted by this Notice.
- In the event of your incapacity or in emergency circumstances, we will disclose heath information to a family member, friend, or other person as necessary only if authorized to do so.
- We will not use your health or personal information (i.e. address & phone number) for marketing purposes.
- We may use or disclose your health information to authorities when we are required to do so by law, including for public health reasons (e.g. disease reporting) if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim or other crimes.
- You have the right to review or receive copies of your health information, with limited exceptions.
- You have the right to request that we amend your health information. Such request must be made in writing, and must explain why the information should be amended. We reserve the right to deny your request.

Please know that there is a fee when your records are specifically ordered by an insurance company, lawyer, or court subpoena. This fee is paid by the requesting party. There is no fee to you for this service or if you request that we send your records to another healthcare provider. Refusal to sign that you have received this information will not affect your treatment, eligibility for benefits or payment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I (or my legal guardian or parent) acknowledge(s) that I have received and read the Notice of Privacy Practices. The Notice describes the policies and procedures regarding the use and disclosure of my health information that is created, received or maintained by Center for Chiropractic & Pain Rehabilitation.

Name of Patient: _____
Please Print

Name of Guardian/Parent: _____ **Relationship:** _____
(If patient is a minor in or under guardianship) Please Print Please Print

Signature of Guardian/Parent: _____ **Date:** _____

FOR OFFICE USE ONLY

Patient was unable or unwilling to sign this document**.**
Reason:_____

Signed: _____ Date: _____