

PEDIATRIC PATIENT INTRODUCTION 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:		
Parents Names:		Pediatrician/ Current Treating Physician: Phone number and/or address:		

<input type="checkbox"/> YES, <input type="checkbox"/> NO I authorize the following telephone numbers: <input type="checkbox"/> YES, <input type="checkbox"/> NO I authorize the use of my name/address Home: _____ Work _____ Cell: _____ Please star (*) your preferred phone number E-mail Address: _____ I have read and understand my right to privacy, as stated to the right, and agree to have the practitioners and employees of CCPR maintain my records confidentially in accordance with the law. I agree to inform CCPR if I need to have any special arrangements pertaining to this issue. Parent/Guardian Signature: _____ Date: _____	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 our 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. Please list telephone numbers to the left that are acceptable for our office to call.
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CONSENT FOR TREATMENT OF A MINOR:
I _____ hereby authorize Center for Chiropractic & Pain Rehabilitation to administer treatment, as they deem appropriate for my child/dependent _____ (full name of dependent). Your Signature: _____ Relationship to Dependent: _____

Emergency Contact: _____ **Phone:** _____

HEALTH INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	<input type="checkbox"/> Yes, <input type="checkbox"/> No
If yes, we will need to make a copy of your insurance.	Insurance Name: _____ Address: _____ Telephone: _____

AS A COURTESY, CCPR WILL BILL YOUR INSURANCE COMPANY. HOWEVER, YOU ARE ULTIMATELY RESPONSIBLE FOR THE BILL. UNTIL BENEFITS ARE CONFIRMED, A 30% CO-PAY WILL BE COLLECTED AT THE TIME OF SERVICE. WE EXPECT PAYMENT AT THE END OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR HEALTH INSURANCE PATIENTS.

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 clinical 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 which would not otherwise be obvious to the DC. I understand that if I am accepted as a patient by a DC at CCPR, I am authorizing them 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 and Date	I am the responsible party. I agree to the above missed appointment and informed consent policies and 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.
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PEDIATRIC GENERAL HEALTH HISTORY

REASON FOR TODAY'S VISIT

<input type="checkbox"/> Wellness Check-up	<input type="checkbox"/> Infant Examination
<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Fussy Baby/ Colic
<input type="checkbox"/> School/Sports/Camp Physical	<input type="checkbox"/> Nursing Difficulties
<input type="checkbox"/> Sleep Difficulties	<input type="checkbox"/> Ear Pain/ Infection
<input type="checkbox"/> Birth Trauma	<input type="checkbox"/> Headaches
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Growing Pains
<input type="checkbox"/> Injury	<input type="checkbox"/> 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.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Torticollis	<input type="checkbox"/> Nocturnal Enuresis (bedwetting)
<input type="checkbox"/> Developmental Delays	<input type="checkbox"/> Autism/Aspergers	<input type="checkbox"/> Learning Difficulties/Disabilities
<input type="checkbox"/> Gastric Reflux	<input type="checkbox"/> Sensory Integration Difficulties	<input type="checkbox"/> Balance problems
<input type="checkbox"/> Food Sensitivities	<input type="checkbox"/> Dermatitis/Rash	<input type="checkbox"/> 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: _____