Welcome Intake Age Infant-3years

Child

Today's Date ___/___/___
Child's full name_____
Child's Nickname_____Boy___Girl___
Birthdate: ___/___/___ Age:___ Grade:___
School: _____ SS#_____

Child's Home Phone#: _____
Child's Home Address:_____
_____

Reason for Visit:_____
_____

Family Information

Delivery:
Natural__ Cesarean__ Forceps__ Vacuum___
Length of labor: _____ Weeks Gestation:____
Pain Medication during Labor: Yes___ No____
Number of days in hospital: _____
Problems during Pregnancy? Yes__ No __
Problems after birth? Yes__ No__
If Yes, please explain_____
_____
Birth Weight____ Length____ Blood Type____
Breast Fed? Yes__ No__ How Long? _____
Fed Formula? Yes__ No__ Birth Order _____

Birth

Mother's name:_____
Home Phone:_____Work Phone:_____
Employer/Occupation:_____
Father's name:_____
Home Phone:_____Work Phone:_____
Employer/Occupation:_____

Development

Please list age of the following events
Sat Alone:_____ Stood Alone_____
Walked Alone____ First Words____
First Tooth:____ Toilet Trained____

Medical History

List any allergies your child has____
_____
List any over the counter medications, vitamins or herbs your child is taking_____

_____
List any previous surgeries/treatment
Injuries or broken bones with dates:
_____
Please list dates of when your child following illnesses: Measles___/___
Mumps__/__ German Measles__/__
Rheumatic Fever___/___
Chicken Pox__/__ HIV/AIDS__/__
Cancer___/___ Pneumonia ___/___
Tuberculosis___/___ Asthma ___/__
Urinary Tract Infection ___/___
Diabetes __/__ Ear Infections __/__
Other Illnesses/accidents:?_____
_____
Number of Antibiotics received:____

Habits

Does child sleep through the night?_
Is your child Happy?_Fussy?When?
What are some favorite foods?_____

Vaccinations

Please list the dates of vaccination.
Hepatitis ___/___ Hib___/___
MMR __/__ DPT__/__chicken pox _

Insurance Information

Primary Insurance Company
Company Name:_____
Address:_____
_____
Phone#:_____Group #_____
Insured's name_____Relation__
Birthdate:__/__/__ Insured's SS#_____
Insured's Employer_____

Secondary Insurance Company
Company Name:_____
Address:_____
_____
Phone #:_____Group #:_____
Insured's name_____Relation_____
Birthdate:__/__/__ Insured's SS#__
Insured's Employer_____

In the Event of an Emergency, Who Should We Contact?
Their Name: _____Relation:_____
Work Phone#:_____Home Phone#:_____

Account Information

Person Ultimately Responsible For Account
Name:_____Relation:_____
Billing Address:_____
Home Phone#:_____Employer:_____Work Phone:_____

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider, parent and patient.

Our office policy requires payment in full for all services at the time of visit. The person bringing the patient to this office is responsible for charges unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

I under stand the above information, guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes in my child's medical status.

Date:___/___/___ Signature of Responsible Person:_____

Falls Healing Arts S.C.

Consent to Treat:

The primary treatment used by Doctors of Chiropractic is the spinal adjustment. We will primarily use that procedure to treat you. The doctor may use his or her hands or a mechanical device upon your body in such a way as to move, or adjust, your joints. Additionally, other treatments may be used to help you, and will be explained to you at the time the Doctor decides to utilize these techniques or treatments.

The side effects associated with a chiropractic adjustment are extremely rare. Initially, a small amount of soreness may be expected in certain cases, but this can be discussed with the Doctor. Any other concerns or questions may also be discussed with the Doctor.

By signing below you state that you are wiling to undergo a chiropractic examination, x-rays of the spine or the area(s) involved (if indicated), and chiropractic treatment as may be outlined by the Doctor after the examination has been done.

In addition, it is important to understand that health and accident insurance policies are arrangements between you and your insurance carrier. As a courtesy to you, our office will bill your insurance company under normal circumstances and will complete any necessary forms to assist you in collection of payment from your insurance company assuming you have assigned benefits to be paid directly to our office. However, please understand that you are personally responsible for any and all charges regardless if your insurance company pays or not.

Signature: _____ Date: _____

Consent to treat minor child: _____

Relation: _____

Consent for Use and Disclosure of Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPPA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information:

- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the front desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices, please see the "NOTICE OR PRIVACY PRACTICES" binder in reception or ask for a copy at the front desk.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, courtesy call, balances due, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving messages from the automated outreach and messaging system, when necessary.

_____	_____	_____
Name (Printed Please)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Name (Printed Please)	Signature	Date