New Child Patient Application

Patient information

Name:_____ Date of Birth:_____ Date:_____

Address_____City:_____State:_____Zip:_____

Parent or Guardian Information

Name:_____ Occupation:_____Employer:_____

Cell Phone: _____ Cell Phone provider: _____ Would you like to receive text message reminders? **Y/N**

Marital Status: S M D W Spouse's name and occupation:_____

Mother's Pregnancy and Labor

During pregnancy did you use (please circle all those that apply): drugs medications tobacco alcohol

If yes, please explain_____

Describe your delivery:

Yes or No Labor was chemically induced? Yes or No Labor was Doctor assisted?

Yes or No C-section delivery? Yes or No Forceps/vacuum extraction?

Yes or No Doctor pulled or twisted baby? Yes or No Premature delivery?

Please explain_____

Yes or No Did you nurse the baby? Yes or No Did you experience feeding problems?

Yes or No did your baby have colic? Yes or No Vaccinations?

Please explain_____

Patient History

Have ever received Chiropractic care? Yes or No Have you ever been in an accident ? Yes or No

When?_____What was the nature of the accident?_____

_____

About the Patient's Health

The human body is designed to be healthy. Throughout life, events occur which hinder your body's ability to be well. Please answer these questions to the best of your ability to help your Doctor fully assess your health needs.

Yes or No Do you eat healthy food?_____

Yes or No Do you or have you ever been vaccinated?_____

Yes or No Prescription/ OTC drugs?_____

Yes or No Do you have eye problems?_____

Yes or No Do you have hearing problems?_____

Yes or No Do you get at least 8 hours of sleep each night?_____

Please circle all that apply:

Headache	Allergies	Shortness of Breath	Asthma	Attention Problems
Fatigue	Stiff Neck	Sleeping Problems	Bed Wetting	Ear Problems
Frequent Colds	Fever	Colic	Irritability	Eye Problems
Cold Feet	Constipation	Hyperactivity	Fainting	Skin Problems
Cold Hands	Diarrhea	Upset Stomach	Loss of Smell	Loss of Balance
Loss of Taste	Tension	Tubes in Ears	Buzzing in Ears	Loss of Memory

Other_____

Present Complaints

Major complaint: _____ Onset date? _____

Is this condition getting worse? **Y/N** Pains are: Sharp Dull Aching Throbbing Other: _____

What activities aggravate your pain? _____

What medications are you taking for this complaint? _____

Other complaint: _____ Onset date? _____

Is this condition getting worse? **Y/N** Pains are: Sharp Dull Aching Throbbing Other: _____

What activities aggravate your pain? _____

What medications are you taking for this complaint? _____

Have you had any surgeries? **Y/ N** For what? _____ When? _____
did you experience any side effects from the drugs or surgery? _____

What type of care are you looking for?

Patch Care ***Rehabilitation Care*** ***Wellness Care*** ***Not sure, I'd like to discuss this with Dr Todd***

Terms of Acceptance

When a patient seeks Chiropractic Health Care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is specific application of force to facilitate the body's correction of a vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.

Vertebral Subluxation: A misalignment of one or more of the (24) vertebra in the spinal column which causes an alternation of nerve function and interference to the transmission of nervous impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than a vertebral subluxation. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct a vertebral subluxation.

I,_____, have read and fully understand the above statements.

I, therefore, accept chiropractic care on this basis.

Signature of Parent or Guardian_____Date:_____

Patient's name (please print):_____

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for services rendered will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed upon that the payments to the Doctor for X-rays is for examination of the X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

Signature of Parent or Guardian _____Date:_____

Print name:_____Patient name:_____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records with a request. You may request to view changes to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (*HIPAA),* I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Signature_____Date:_____

Print name:_____Patient name:_____

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, overdue wellness exam, balances due, lab results, 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 the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

_____ _____

Patient Signature Date