PEDIATRIC PATIENT INTRODUCTION

Child's Name:_____ Mother's Name:_____

Date: _____/_____/_____ Father's Name: _____

Address: _____City/Town:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____Work Phone: _____

Birth Date: _____/ _____ / _____ Age: _____ Sex: _____

APGAR Scores: _____Presence at birth of:_____ - Jaundice (Yellow) ❑ - Cyanosis (Blue) ❑

Check any of the following conditions your child has suffered from during the past six months:

❑ Ear Infections	❑ Scoliosis	❑ Seizure	❑ Chronic Colds	❑ Headaches
❑ Asthma / Allergies	❑ Digestive Problems	❑ ADHD	❑ Recurring Fevers	❑ Growing / Back Pains
❑ Colic	❑ Bed Wetting	❑ Car Accident	❑ Temper Tantrums	❑ Other _____

Family History:

Previous Chiropractor: _____
Date of Last Visit: _____ / _____ / _____ Reason: _____
Name of Pediatrician: _____
Date of Last Visit: _____ / _____ / _____ Reason: _____
Are you satisfied with the care you child has received there? ❑YES ❑NO
Number of doses of **antibiotics** your child has taken:
During the past six months: _____ Total during his/her lifetime: _____
Number of doses of **other prescription medications** your child has taken: _____
During the past six months: _____ Total during his/her lifetime: _____ List: _____
Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____
Complications during pregnancy? ❑YES ❑NO List: _____
Ultrasounds during pregnancy? ❑YES ❑NO Number: _____
Medication during pregnancy/delivery? ❑YES ❑NO List: _____
Cigarette/alcohol use during pregnancy? ❑YES ❑NO

Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home
Birth intervention: ❑ Forceps ❑ Vacuum Extraction ❑ Cesarean Section, (Emergency or Planned?)_____

Complications during delivery? ❑YES ❑NO List: _____
Genetic disorders or disabilities? ❑YES ❑NO List: _____
Birth weight: _____ Birth length: _____ APGAR scores: _____, _____

_____

Congenital anomalies/ defects: _____

Infant feeding: _____Breast _____Bottle _____Formula _____

#of hours of sleep /night: _____ Quality of sleep: ❑good ❑fair ❑poor

Immunization history: _____

Purpose of this appointment: _____

Has your child been treated on an emergency basis? _____

Describe: _____

Childhood Diseases:

Chicken Pox	❑ Age: _____	Mumps	❑ Age: _____
Rubella	❑ Age: _____	Whooping Cough	❑ Age: _____
Rubeola	❑ Age: _____	Other	❑ Age: _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care as they so deem necessary to my son/daughter.

Name of Insurance Company: _____ Policy #: _____

Signed: _____Witnessed: _____Date: _____/_____/_____

I realize that I am responsible for all fees charged by this office and that I will pay for all services as they are performed. X-rays remain the property of this office.

Date: _____/_____/_____ Signature: _____

NOTICE OF PRIVACY PRACTICE (HIPAA)

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients' privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. Frasco Chiropractic, we are very careful to keep your health information secure and confidential. This new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact Frasco Chiropractic.

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. Open adjusting involves adjusting patients in a semi-private setting. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

The use of this format is intended to make your experience with our office more efficient and productive; it is our goal to reduce waiting times as much as possible. If you choose not to be adjusted in an open adjusting environment, a private room is always available.

Signature _____ Date _____

Frasco Chiropractic Office, LLC.
1806 Springfield Avenue, New Providence, NJ 07974
Telephone: (908) 771- 0707 - Fax: (908) 665 2067

PLEASE MAKE A NOTE OF OUR OFFICE HOURS!

Regular adjustments are done during **adjustment hours** ONLY. This is so that we may set aside uninterrupted time for scheduled reports. If you cannot make your adjustment time, kindly call the office and we will reschedule you for the next adjustment hour session.

X-rays, reports, and extended office visits are done during **report hours** ONLY. If you have a new injury or problem, you will need to schedule extra time with Dr. Frasco during the report hours. This way the doctor can spend uninterrupted time with you to correctly evaluate your condition. Please do not come to the office during your adjustment time asking for the doctor to evaluate a new condition or injury. This causes a unnecessary increase in waiting times for other patients.

On Tuesday nights, Dr. Frasco gives the New Patient Workshop promptly at 6:00 p.m. This workshop is required for all new patients. Your home exercises will be given following the workshop. We encourage you to attend additional workshops as many times as you like since they all have different health information, and remember we welcome your friends and family!

Monday, Wednesday, Thursday

Adjustment hours	7:00 a.m. - 8:45 a.m.
Report hours	9:00 a.m. - 10:30 a.m.
Adjustment hours	10:30 a.m. -12:00 a.m.
Adjustment hours	2:30 p.m. - 3:15 p.m.
Report hours	3:30 p.m. - 4:15 p.m.
Adjustment hours	4:30 p.m. - 6:00 p.m.

Tuesday

Adjustment hours	2:30 p.m. - 3:15 p.m.
Report hours	3:30 p.m. - 4:15 p.m.
Adjustment hours	4:30 p.m. - 6:00 p.m.

Saturday

Adjustment hours	8:00 a.m. - 11:00 a.m.

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