Notes

BP:

SeaCoast
FAMILY CHIROPRACTIC

PATIENT NAME: _____

DATE OF X-RAY: _____

CHIEF COMPLAINT: _____

_____

X-RAY FINDINGS: _____

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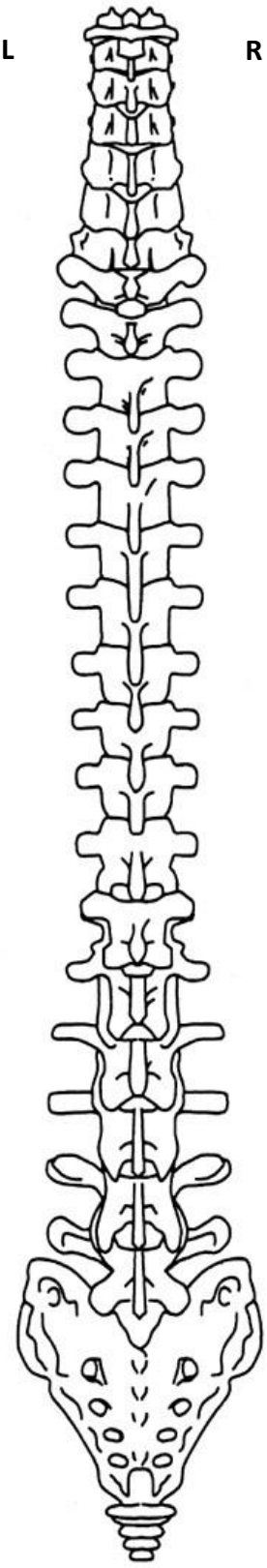

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AX _____
C3 _____
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SAC _____
S2/S3_____
LT IL _____
RT IL _____
COC _____
Other:_____

_____

SeaCoast
FAMILY CHIROPRACTIC

Pediatric History Form

Name: _____ Date: _____/_____/_____

Name of Parents/Guardians: _____

Address: _____State: _____Zip:_____

H. Phone: (_____)_____ W. Phone: (_____)_____

C. Phone: (_____)_____ Email Address: _____

DOB: _____/_____/_____ Age: _____ Sex: _____ Height: _____ Weight: _____

Number of Siblings: _____ SS #: _____Who referred you to us? _____

Reason for seeking Chiropractic Care: _____

Other Doctors seen for this condition Y / N (Specialty): _____

Prior treatment outcome: _____

Other health problems: _____

Symptoms: *Please check any current or past problems your child has on the list below:*

__Dizziness	__Allergies	__Diarrhea	__Broken Bones
__ADHD/ADD	__Runny nose	__Poor Appetite	__Sprains/Strains
__Backaches	__Itchy Eyes	__Hyperactivity	__Hernias
__Heart Condition	__Rashes	__Behavioral	__Neck Pain
__Chronic Earaches	__Unusual Moles	__Poor Memory	__Arm/Elbow Pain
__Diabetes	__Neuritis	__Insomnia	__Leg/Hip Pain
__Tuberculosis	__Digestive	__Nightmares	__Knee/Foot Pain
__Hypertension	__Sinus Trouble	__Bed Wetting	__Growing Pains
__Fever/Chills	__Cough/Wheeze	__Pain Urinating	__Joint Pain
__Frequent Colds	__Chest Pain	__Scoliosis	__Convulsions/Paralysis
__Arthritis	__Constipation	__Muscle Pain	__Blood Disorders
__Headaches	__Anemia	__Fainting	__Stomach Aches
__Asthma	__Rheumatic Fever	__Other: _____	

Explain checked conditions: _____

_____

_____

Please answer all questions to the best of your ability. Thank you:

Health History:

Name of Pediatrician: _____ Date of last visit: _____/_____/_____

Reason for visit: _____

Medications and conditions being treated: _____

Has your child ever taken antibiotics? Y / N Condition treated: _____

Has your child been injured participating in contact sports? (Soccer, Football, Martial Arts…) Y / N

Explain: _____

If yes, describe (Sprain, Broken Bone, Head Trauma…): _____

Has your child ever been involved in a car accident? Y / N Date & Injuries: _____

_____

Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y / N _____

Other traumas not described above? Y / N Type & Date: _____

Prior Surgery: Y / N Type & Date: _____

_____

_____

Prenatal History:

Location of Birth (check one): __Home __Birthing Center __Hospital __Stepchild __Adopted

Complications during pregnancy: Y / N List: _____

Ultrasounds during pregnancy/delivery: Y / N How many? _____

Medications during pregnancy/delivery: Y / N List: _____

Cigarette/Alcohol use during pregnancy: Y / N Describe: _____

Complications during delivery: Y / N List: _____

Genetic disorders or disabilities: Y / N List: _____

Birth Weight: _____ Birth Length: _____ APGAR scores: 1 min_____ 5 min _____

Regarding your Birth Process:	[Please Describe if Applicable]	[Doctor's Comments]
Was the delivery long/difficult?	Y / N _____	_____
Forceps or Extraction used?	Y / N _____	_____
Cesarean/C-Section?	Y / N _____	_____
Breach/Cephalic?	Y / N _____	_____
Home Birth?	Y / N _____	_____
Hospital Birth?	Y / N _____	_____
Mother given drugs during delivery?	Y / N _____	_____
Was labor induced?	Y / N _____	_____

Feeding History:

Breast Fed: Y / N How long? _____ Formula fed: Y / N How long? _____

Formula type: _____ Introduced to solids at _____ months. Cow's milk at _____ months

Food / Juice allergies or intolerances: Y / N List: _____

Developmental History:

Sleep (hours per night): _____ Naps: (number & lengths): _____ Problems sleeping: Y / N

At what age was your child able to:

Crawl_____ Sit alone_____ Stand alone_____ Walk alone_____ Say words_____

Childhood Diseases:

__Chicken Pox	Age: ____
__ Mumps	Age: ____
__Rubella	Age: ____
__Whooping cough	Age: ____
__Measles	Age: ____
__Meningitis	Age: ____
__Tuberculosis	Age____
__Other: _____	Age: ____

Vaccination History:
Check all that apply.

__HBV/Hep B (Hepatisis B)	Age: ____
__MMR (Measles, Mumps, Rubella)	Age: ____
__DTP or __DTaP (Diphtheria, Tetanus, Pertussis: DPT)	Age: ____
__Varicella (Chicken Pox)	Age: ____
__HbCV/Hib (H. influenza type b conjugate)	Age: ____
__PCV (Pneumoccocal)	Age: ____
__OPV (Oral Polio Vaccine)	Age: ____
__IPV (Inactivated Poliovirus)	Age: ____

Adverse reactions to any vaccine? Y / N Describe: _____

_____

_____

Insurance:

Do you have medical insurance? Y / N Insurance Company Name: _____

Policy Number: _____ Insurance Company Phone #: _____

Insured's Name: _____ Relationship to the patient: _____

Insured's DOB: _____ Insured's SS#:_____

Employer: _____ Employee Address: _____

Consent to Chiropractic Care

I certify that the information that I have supplied is correct and accurate to the best of my knowledge. I,_____, being the parent or legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

Signed: _____ Witnessed: _____

Date: _____

HIPAA LAW # 101-191 Consent Form

The information you provide us is kept in the strictest of confidence.

While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health care information:

1. It may be necessary to use or disclose your private health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health information.
2. It may be necessary to use or disclose you private health information and billing records to another party if they are responsible for the payment of your services.
3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes including:
    - Appointment reminders at home
    - Appointment reminders at your work
    - Appointment reminder card or post cards
    - Leaving a message on a voicemail or answering machine
    - Leaving a message with a person at your work or home
    - Testimonials of your improvement in written or verbal form
    - Sending you a newsletter
    - "thank you" gifts
    - Family picture boards
    - Sending you marketing materials
    - Information about alternative treatments
    - Other health related information that may be of interest to you

Patient Rights under HIPAA LAW #101-191

1. You have the right to request that we do not disclose your private health information to specific individuals, companies or organizations under the following circumstances:
    - All requests must be in writing.
    - By law we are not required to agree with your restrictions, however
    - If we agree with your restrictions, the restriction is binding on us.
2. You have the right to REVOKE your Authorization under certain conditions:
    - It must be in writing
    - The request will not be honored if we have already released your private health information before we received your request to revoke the authorization.
    - If you were required to give your authorization as a condition of obtaining insurance, the insurance may have their right to your private health information should they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the reminder of other information and may no longer be protected by the federal privacy rules.
    - If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for services rendered to you.

I have read your consent policy and agree to its terms. I also acknowledge that once I sign this consent form I will receive a copy of this completed form for my own records. This notice is effective on the date below and will expire seven years after the date upon which the record was created.

_____ _____

Print Your Name Authorized Signature

_____ _____

Signature Date

Note: We have a more detailed "Notice of Privacy for Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changed occur in reference to our privacy practices you will be notified by posting of the change in the office or a notice will be send to you in the mail. You may request a copy of our privacy notices at any time.

SeaCoast
FAMILY CHIROPRACTIC

Assignment of Benefits Form

Name of insured: _____

Insurance I.D. Number: _____

I hereby assign all medical benefits to which I am entitled to Sea Coast Family Chiropractic. This applies for all insurance carriers, including Medicare, private insurance, and any other health/medical plan. This form will be kept on file.

I understand that it is my responsibility to report any changed in insurance coverage.

I authorize Sea Coast Family Chiropractic to submit claims to my insurance company on my behalf and I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for continued medical care.

I understand that I am financially responsible for any amount not covered by insurance.

Signature: _____ Date: _____ /_____ /_____