Dr. Jessica Paige
Chiropractor

1620 Westwood Drive, Suite D, San Jose CA 95125 408-385-1849 www.drjessicapaige.com

PLEASE PRINT

Child's Full Name: _____ Date: _____

Parent #1 Name: _____ Parent #2 Name: _____

Child's Home Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Parent #1 Phone Work and/or Cell: _____

Parent #2 Phone Work and/or Cell: _____

Parent Email Address(es): _____

BIRTH INFORMATION

Birth Date _____ Sex _____ Birth Weight _____ Birth Length _____ Current Age of Child _____

Type of Birth: Vaginal ___ Forceps ___ Breech ____ Cesarean _____ Home _____ Birthing Center _____ Hospital _____

Medication taken during pregnancy? _____ Epidural: □ YES □ NO

Any problems during pregnancy and/or labor? There is more space on next page for additional information. _____

_____

_____

Apgar Scores: _____ Jaundice (yellow) at Birth? _____ Cyanosis (blue)? _____

Congenital Anomalies/Defects: _____

Infant Feeding: Breast _____ Bottle _____ Formula _____ Other Food or Drink Information: _____

_____

No. of Hours Child Sleeps Daily _____ Quality of Sleep: Good _____ Fair _____ Poor _____

Explain: _____

Number of Siblings _____ Siblings Name, Age and Sex _____

ADOPTION INFORMATION

Child's Age When Adopted _____ Date of Adoption _____

Known Health History of Child _____

_____

HEALTH AND MEDICAL INFORMATION

Obstetrician and/or Midwife Name: _____ Location: _____

Pediatrician and/or Family MD Name: _____ Location: _____

Date of Last Visit to Dr: _____ Purpose of that Visit: _____

_____

Immunization History: _____

_____

Has your child ever been treated on an emergency basis? _____ Please Describe: _____

_____

Purpose of the appointment today with the Chiropractor: _____

_____

_____

Pregnancy History: _____

_____

_____

Delivery/Birth History: _____

_____

_____

Developmental History – At What Age Did the Child:
Respond to Sound _____
Crawl _____
Follow an Object with their Eyes _____
Hold Head Up _____
Stand _____
Sit Alone _____
Walk Alone _____

Childhood Diseases – Age of the Child When Occurred:
Chicken Pox _____
Rubella _____
Rubeola _____
Whooping Cough _____
Mumps _____
Measles _____
Other _____

Has this child ever suffered from (please check any that apply):

- ☐ Diabetes
- ☐ Fainting
- ☐ Dizziness
- ☐ Asthma
- ☐ Sugar Concentration
- ☐ Sleeping Problems
- ☐ Diarrhea
- ☐ Arm Problems
- ☐ Arthritis
- ☐ Behavioral Problems
- ☐ Bed Wetting
- ☐ Tuberculosis
- ☐ Stomach Aches
- ☐ Walking Problems
- ☐ Headaches
- ☐ Digestive Disorders
- ☐ Constipation
- ☐ Hyperactivity
- ☐ Neuritis
- ☐ Muscle Jerking
- ☐ Convulsions
- ☐ Backaches
- ☐ Allergies
- ☐ Rheumatic Fever
- ☐ Blood Disorders
- ☐ Sinus Trouble
- ☐ Paralysis
- ☐ Chronic Earaches
- ☐ Anemia
- ☐ Ruptures/Hernias
- ☐ Neck Problems
- ☐ Heart Trouble
- ☐ Orthopedic Problems
- ☐ Hypertension
- ☐ Broken Bones
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Colds/Flu
- ☐ Poor Appetite
- ☐ “Growing Pains”
- ☐ Any Other Problem _____

Present Health History or Additional Information: _____

_____

Surgery Information: _____

Medications: _____

Accidents: _____

Family Health History: _____

_____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treats me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s} for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name: _____

Patient Signature: _____ Date signed: _____

TO BE COMPLETED BY PATIENT S REPRESENTATIVE

IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient s Name: Name of Representative: _____

Date signed: _____ Signature of Representative: _____

Relationship or Authority of Patient's Representative: _____

LICENSED DOCTOR

Dr. Jessica Paige, B.S., D.C. DC-29172
1620 Westwood Drive, Suite D
San Jose, CA 95125
408-385-1849

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices (posted in the office) and I have been provided an opportunity to review it. This document states that your medical information will not be given to anyone without your written permission.

Name: _____ Birth date: _____

Signature: _____ Date: _____

Financial Guidelines

Thank you for choosing our office for your health care. Our office is dedicated to providing the finest quality health care with the best possible service available to you. Our financial guidelines are based on an open and honest discussion of our fees. Please read and sign this document.

Payment: We accept Cash, Checks, Visa and MasterCard. Payment for treatment is due **AT THE TIME SERVICES** are rendered. We do not send monthly statements. Initial _____

Financial Consent: The patient (guardian) agrees to be fully responsible for the total payment of the treatment performed in this office Initial _____

Insurance: As a service to our patients, we will bill some insurance companies (Blue Shield, Medicare, & some PPO plans). Your insurance policy is a contract between ***YOU*** and ***YOUR INSURANCE COMPANY***. As a health care provider, **we are not a part of that agreement**. As a courtesy to you, we will collect your **estimated** patient's portion at the time of your visit and bill your insurance company for the balance. **If your insurance company does not pay as expected, or delays payment beyond 90 days, you are responsible for the balance.** Our goal is to help you achieve and maintain optimum health, which is not necessarily the goal of your health care insurance company. We are always available to answer your questions regarding this matter. If your insurance company adjusts our fees, the resulting balance will be your responsibility. **Please verify your benefits with your insurance company, what they tell us is NOT a guarantee of coverage.**

Initial _____

Minors: Payment for services of the treatment of minors is the responsibility of the adult accompanying the minor.

Initial _____

Missed Appointments: Your appointment time has been reserved specifically for you. If you choose to **CANCEL** or **RESCHEDULE** an appointment with **LESS THAN 24 hours notice**, by phone, online (Setmore) or email, or if you fail to appear for an appointment, ***you will be CHARGED $80*** for that appointment. We cannot make special circumstances for every individual therefore the policy pertains to all cash and insurance paying patients. Insurance **WILL NOT** be billed for the missed visit. Both the Wellness Plans and Visit Plans have their own specific missed appointment policy (see them for 24 hour policy).

Initial _____

Late Arrival For Your Appointment: The office strives to maintain a punctual schedule. If you arrive 10 minutes or more after your scheduled appointment time we CANNOT guarantee you will be seen at that time. You will be rescheduled according to availability and subject to the 24 hour missed appointment policy. Initial _____

Past Due Charges: An interest charge of 1.5% per month (18% ANNUAL PERCENTAGE RATE) will be applied to your account if over 90 days past due. Any accounts which are over 120 days past due may be referred to our collection agency. Interest does not occur on the outstanding insurance portion as a courtesy to you. A charge of $35.00 will occur for returned checks. Initial _____

Collection Fees: Fees incurred to collect payment will be billed to and is payable by the patient.

Initial _____

I, the undersigned, have read the above financial guidelines, and agree to abide by these policies.

Sign name:_____ Date:_____

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