# PEDIATRIC PATIENT INTRODUCTION CARD

Date:_____

Child's Name:_____Age:_____Date of Birth:_____Sex: M F

Street Address:_____City, ST, Zip:_____

Parent's Names:_____

Phone:_____Email:_____

Whom may we thank for referring you to our office?_____

Reason for coming to our office:_____

Name of Person Responsible for the Account:_____

Relationship to Patient:_____Preferred Phone #:_____

Address (if different than above):_____

Insurance Company:_____Name of Insured:_____

Relationship to Patient:_____Date of Birth:_____

***Present Health Challenge(s)***

For what health challenge(s) is your child here for? When did it begin?

_____

Has your child seen other health care practitioners for this? What did they recommend?

_____

What was the outcome of prior treatment/recommendations?

_____

Is this dysfunction getting progressively worse? ___Yes ___No

*Health History*

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

__Anemia
__Arthritis
__ADHD
__Allergies
__Anxiety
__Arm/Elbow Pain
__Asthma
__Autism
__Backaches
__Behavioral Issues
__Bed Wetting
__Blood disorders
__Broken bones:_____
__Chest Pain
__Chronic Earaches
__Colic
__Concussions
__Constipation
__Convulsions
__Cough/Wheeze
__Diabetes
__Diarrhea
__Digestive Problems
__Dizziness
__Eczema
__Fainting
__Fever/Chills
__Frequent Colds
__Growing pains
__Headaches
__Heart Condition
__Hernias
__Hyperactivity
__Hypertension
__Joint Pain
__Insomnia
__Itchy Eyes
__Knee/Foot Pain
__Leg/Hip Pain
__Muscle Pain
__Neck Pain
__Nightmares
__Poor Appetite
__Poor Memory
__Rashes
__Reflux/Spitting up
__Runny Nose
__Scoliosis
__Sinus Trouble
__Sprains/Strains
__Stomach Aches
__Unusual Moles
__Other_____

Name of Pediatrician:_____Date of Last Visit:_____

Current Medications & Vitamins:_____

Past Trauma (falls, sports injuries, accidents, etc)_____

Past Surgeries:_____

**Prenatal History**

Location of Birth: ___ Home ___ Birthing Center ___ Hospital

Complications during pregnancy: Y - N List: _____

Medications during pregnancy/delivery: _____

Cigarette / Alcohol use during pregnancy: Y - N

Birth intervention: ___ Forceps ___ Vacuum ___ Caesarian

Complications during delivery: Y - N List: _____

Birth weight_____ Birth length_____

**Feeding history**

Breast Fed: Y - N How long'?_____ Formula fed: Y - N How long'?_____ Type:_____

Introduced to cereal at____months. Solids at _____ months. Cow's milk at _____ months

Food / juice allergies or intolerances Y - N List: _____

**Developmental History**

Sleep (Hrs per night) _____ Problems sleeping _____

**Medical/Vaccination History**

Has your child ever had an adverse reaction to a prescription or over-the-counter medication? Y – N

If yes, please

explain:_____

Has your child been vaccinated? Y – N Adverse reactions to any

vaccine?_____

**Childhood Diseases**

___Chicken Pox : Age ____ * ___ Mumps: Age ____ * ___ Rubella: Age ____ * ___ Whooping cough: Age ____

___ Measles: Age ____ * ___ Meningitis: Age ____ * ___ Tuberculosis: Age ____ * ___ Other: Age ____

## CONSENT FOR TREATMENT OF MINOR

I hereby certify that the information I have provided is correct and accurate, to the best of my knowledge.

I, _____ , as the parent/guardian of this child, _____ , hereby grant permission for my child to receive examination and chiropractic treatment as deemed necessary.

_____ _____

Signature of Parent or Guardian Date

Wilson Family Chiropractic Clinic
Pinnacle C.O.P. Manual-1.0
Revised 9.23.2014

Patient Name: _____ D.O.B.:_____ Date:_____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

**AUTHORIZATION:** By signing below you authorized this office/provider to complete a consultation and examination on the above.

**AUTHORIZATION FOR X-RAY WITH RELEASE:** By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

**ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS:** By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

**CMS-1500 HEALTH INSURANCE CLAIM FORM**: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

**ACKNOWLEDGEMENT OF TREATMENT PLAN:** By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

**ACKNOWLEDGEMENT:** By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: _____

Signature of Parent or Guardian: _____