WELCOME TO FAMILY FIRST CHIROPRACTIC
PEDIATRIC FORM

Name:	**Today's Date:**	
What Patient Prefers to be Called:		
Parents'/Guardian's Names:		
Home Phone:	**Parent's Cell:**	
Mailing Address:	**City:**	**Zip:**
Child's Birth Date:	**Age:**	**Sex: □ Male □ Female** **Social Security #:**
Parent's Email Address (for newsletter and appointment information):		
How did you learn about our office?		
Previous Chiropractic Care? □ Yes □ No	**Approximate Last Visit Date:**	

Please check reasons for pursuing chiropractic care for your child:

____ He/She is continuing ongoing care from another chiropractor.

____ I recently had my spine checked and see the value in getting my child checked.

____ He/She has a specific condition that concerns me.

Chief Complaint: _____

Location of complaint: _____

Complaint began when and how: _____

Circle quality of pain/complaint: dull aching sharp shooting burning throbbing deep nagging other_____

Does the complaint/pain radiate or travel to any areas of your body □Y □ N Where?_____

Do you have any numbness or tingling in your body? □ Y □ N Where? _____

Grade intensity of complaint (0 no pain, 10 worst possible pain) 0 1 2 3 4 5 6 7 8 9 10

How frequent is complaint present and how long does it last:_____

Does anything aggravate or make the complaint worse: _____

Does anything make the complaint better: _____

Have you tried anything besides chiropractic for this complaint? If so, describe: _____

_____

In order for us to better understand your child's current level of health, please check any of the following body signals which he/she has or has had previously:

□Headaches/Migraines □Asthma □Sleep Problems □Weight Problems □ADD/ADHD

□Postural Imbalance □PDD/Autism □Seizures □Frequent Colds □Allergy/Sinus Problems

□Bedwetting □Ear Infection □Car Accident □Colic □Digestive Problems

□Scoliosis □Growing/Back Problems

Other:

_____

_____

Number of doses of antibiotics your child has taken:

During the past 6 months: _____ Total during his/her lifetime: ____ List reasons:_____

Number of doses of other prescription medications your child has taken:

During the past 6 months: _____ Total during his/her lifetime: ____ List reasons: _____

Prenatal History:

Adopted □ Yes □ No Complications during pregnancy? □ Yes □ No List reasons:_____

Ultrasounds during pregnancy? □ Yes □ No Number: _____

Medications/drugs/caffeine use during pregnancy? □ Yes □ No List: _____

Cigarette/Alcohol use during pregnancy? □ Yes □ No Location of birth: □ Hospital □ Birthing Center □ Home

Birth Intervention:

□ Mother Induced □ Mother medicated (Pitocin, etc.) □ Caesarian Section

□ Forceps □ Vacuum Extracted □ Baby given medication after delivery

Complications during delivery? □ Yes □ No List: _____

Genetic Disorders or Disabilities? □ Yes □ No List:_____

Breast Fed? □ Yes □ No How Long? _____ Formula Fed? □ Yes □ No How Long? _____

Food or Other Allergies? □ Yes □ No List: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ex. A bed, changing table, down stairs, etc.). Was this the case with your child?

□ Yes □ No List: _____

Is/Has your child been involved in any high-impact or contact-type sports (ex. Soccer, football, gymnastics, hockey, basketball, cheerleading, martial arts, etc.)? □ Yes □ No List: _____

Has your child been seen in an emergency room? □ Yes □ No List: _____

Prior surgery? □ Yes □ No List: _____

Notice

It is important that our patients and we have the same health objectives regarding chiropractic care. Regardless of **what a disease or condition is called, we do not offer to treat it.** Our only practice objective is to eliminate a major interference to the expression of the body's innate and internal wisdom. Our only method is specific adjustments to correct vertebral subluxations. We believe the greatest Doctor is the one already inside each of our patients, and we only help to maximize their inherent healing power without the use of drugs or surgery.

Disclosures

- Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.
- If my case is accepted by Family First, chiropractic adjustments will be performed in our adjusting area, where others may be receiving adjustments. I understand and consent to this form of care.

_____ _____

Signature **Date**

Please provide a signature for any of the following that apply to you.

Consent to evaluation and adjustment of a minor child

I _____ being the parent or legal guardian of _____
(print name of consenting adult) (print name of minor)

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

Consenting Adult's Signature Date

Pregnancy Release (Females of Child-Bearing Age)

I certify that to the best of my knowledge my child is not pregnant, and Dr's Chae and Monya Tracy and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

_____ _____

Signature Date

Family First Chiropractic

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

☐ I, _____(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

☐ I, _____(print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier. I do understand that PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

Assignment and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt my settlement award(s).

Patient Signature: _____ Date: _____

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as “rare” and the probability of adverse reaction due to ancillary procedures is also considered “rare”.

Patient Signature: _____ Date: _____