Clinton Chiropractic Center
Pediatric History Form under 6 yrs old

Patient Name: ____

Birthdate: ____________ Age: ____ Sex: ____ Weight: ______________ Height: _________________

Parent/Guardian Name: ____

Address: ________________________________ City: ____________ State: _____ Zip: _________

Phone (H)____________________ Cell: ____________________Parent DL#:______________________

Health Insurance Company: ____

ID: ____

Group:______________________________

Purpose of visit: ____

Have you seen other doctors for this condition? **YES / NO**

Doctor's names and prior treatments: ____

Referred By:____

Circle any of the following conditions your child has suffered from: **Ear Infections, Scoliosis, Seizures Chronic Colds Headaches, Asthma/Allergies, Digestive Problems, ADHD, Recurring Fevers Growing Back Pains,Colic, Chicken Pox, Bed Wettting, Rubella, Car accident, Measles, Temper Tantrums, Mumps Whooping Cough, Other:**____

Seen other Chiropractors? **YES / NO** Date of last visit: ______________________________

Reasons:____

Name of Pediatrician: ____

Date of last visit: _______________________ Reason: ______________________________

Number of rounds of antibiotics your child has taken: in the past 6 months:___________

Are your child's vaccinations up to date? **YES / NO**

What sports/activities does your child participate in?

____

Has your child ever been to emergency room? **YES / NO** Why?: ______________________________

Other traumas not described above: ____

Prior Surgery? **YES / NO** List: ____

List relevant major health problems of immediate relatives:

____

Clinton Chiropractic Center
Prenatal History

Patient Name:____

DOB:_____________

Complications during pregnancy? **Yes/No**

List:____

Location of Birth: Hospital   Birthing Center   Home

Birth Intervention: Forceps   Vacuum Extraction   C-Section---Emergency or Planned

Complications during delivery? **Yes/ No**

List: ____

Birth Weigh_________________Birth Length__________________

Born at ____________Weeks

Breast Fed? **Yes/ No** How long? _____________

Formula Fed? **Yes/ No** How long?_____________

Clinton Chiropractic Center

Office Policies & Procedures Agreement

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many Insurance plans, but we also have affordable options for patients without health insurance. Regardless of your coverage, we will suggest the chiropractic care we think you need to get you healthy and keep you healthy.

FINANCIAL ARRANGEMENTS AND POLICIEs

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services are rendered. If this office is billing my insurance for me, my portion would include any deductibles, copayments, or services not covered by my insurance. We do accept personal checks, however there is a $25.00 fee for all returned checks. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours' notice in order to reschedule your appointment.

INSURANCE BILLING/PAYMENT

I understand that I am ultimately fully responsible for products purchased and services provided by this office. This office is a participating provider with several insurance companies. For your convenience, this office will make an effort to verify your insurance benefits. However, ultimately it is the patient's responsibility to determine benefit and authorization information before services are rendered. Please note that verification of benefits is not a guarantee of payment. The insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of products and services not authorized or covered by their insurance company.

CASH PAYMENT POLICIES

This office requests that 100% of the first visit be paid at the time of the visit. We are happy to accept cash, check, Discover, AMEX, Master Card or Visa.

INFORMED CONSENT TO CHIROPRACTIC CARE

I request and consent to the performance of chiropractic examination, adjustment/manipulation and all other chiropractic procedures permitted by our state law, including medical records review, various modes of physiotherapy and necessary diagnostic X-Rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating Doctor of Chiropractic on staff and /or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I have been informed and I understand that in the practice of medicine, in this case chiropractic, there are risks associated with treatment, although rare, including, but not limited to , fracture, disc injuries, strokes, dislocations, strains, and worsening of symptoms, I do not expect the doctor to be able to anticipate and explain all risks and complications of my case, 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 on the facts the known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

In accordance with all stated above, I hereby understand and agree to the above stated office policies.

Patient's Name (Print) ________________________________

Signature: ____________________________________ Date:___/___/______

(Patient, Parent or Legal Guardian)

Clinton Chiropractic Center, LLC
119 N. 9th Street
Clinton, OK 73601
(580) 323-4250

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Regarding the Use & Disclosure of Protected Health Information

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

By signing below I acknowledge that I have read and received a copy (if chosen) of ***Clinton Chiropractic Center, LLC*** *Notice of Privacy Practices.*

Patient Name: ____________________

Signature of patient or personal representative: ____________________

If not patient signature, relationship of representative: ____________________

The following person(s) is allowed to request my personal health records on my behalf:

____

Signature of patient/personal representative: ____________________

Today's date and therefore effective date of this agreement is this date: ____/____/____
Expiration date: December 31, ________

Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: ____________________ Refused to sign ☐ Physically unable to sign ☐

(Other)____________________

____

Employee Signature: ____________________ Date: ____________________

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CONSENT TO TREATMENT OF A MINOR

Minor's Name:______________________________ DOB:____________________

I,______________________ the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize **Clinton Chiropractic Center** to administer treatment as it so deems necessary to the minor. In the event that the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at **Clinton Chiropractic Center** which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form. I further authorize the above mentioned minor to be treated without my presence, either alone or brought by another representative of my choosing, If I am unable to physically be in the office.

Authorized representative(s):

Parent/Guardian Name:

Signature: Date:___/___/___

(Expiration date: December 31, ~~2020~~ 2021)