Patient Information about your child

Patient Name:_____ SSN#:____-____-_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____

D/O/B:_____ Height:_____ Weight:_____ Sex: Male Female

Parents/Guardian Name(s):_____

Parent Daytime Contact Number:_____

Whom do we thank for your referral?_____

Insurance Information

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co_____ Group #_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with above named insurance and assign directly Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature_____

Relationship_____ DOB_____ Date_____

What is the health issue you have contacted us about?_____

Have you seen other doctors for this condition? Yes No

Doctors names and the treatment they recommended:_____

Are there any other health problems?_____

Please circle any of the following conditions your child has suffered from in the past.

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma/Allergies	Colic	ADHD/ADD	Recurring Fevers	Growing /Back pains
Digestive Problems	Bed Wetting	Car Accident	Sleep Issues	Other_____

Are there any chronic diseases or health concerns in your family?_____

Previous Chiropractor:_____ Date of Last Visit:_____

Name of Pediatrician?_____ Date of Last Visit:_____

Has your child been on any medication? Yes No List:_____

Prenatal History:

Any complications during pregnancy?_____

Was there birth intervention? Forceps_____ Vacuum Extraction_____ Caesarian Section – Emergency or planned

Complications during delivery?_____

Other questions:

Was your child breast fed/bottle fed?_____ Formula used?_____

Does your child have any food allergy or intolerances? Yes No List:_____

Does your child have any behavioral concerns?_____

Does your child have any eating/nutritional concerns?_____

Is/Has your child been involved in any high impact sports? (Football, Hockey, Gymnastics)_____

Any trauma or hospitalizations?_____

Any surgeries?_____

AUTHORIZATION FOR CARE OF A MINOR

An **adjustment** is the specific application of forces to facilitate the body's corrections of vertebral subluxation.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

A vertebral subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to express its maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. It you desire advice, diagnosis, or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interferences to the expression of the body's innate wisdom. Our only method is specific adjustments to correct vertebral subluxation.

I hereby authorize this office and its Doctors and assistants to perform diagnostic tests, and to administer treatment as necessary. I, also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that I am personally responsible for payment of all fees charged by this office.

I_____ have read and fully understand the above statements.
(Print Name)
All questions regarding the doctor's objectives to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature_____ Relationship to Patient_____ Date_____

AUTHORIZATION FOR X-RAYS

I hereby authorize this office, it's doctors and assistants to take x-rays of my child.

Signature_____ Relationship to Patient_____ Date_____

CALEASE CHIROPRACTIC CENTER

Privacy Notice to Patients

Effective Date

This Notice is effective as of January 1, 2006

Acknowledgment

I acknowledge that I have received a copy of Calease Chiropractic Center's Privacy Notice that has an effective date of January 1, 2006.

_____ _____

Name of Individual (Printed) Signature of Individual

Date Signed _____/_____/_____