Mohr Chiropractic Clinic

4031 S. Crestview Dr.

Greencastle, Indiana

(765)653-4447

PEDIATRIC NEW PATIENT INFORMATION

PATIENT INFORAMTION:

Child's First Name: ______________________________________ Last Name:_____________________________________

Reason for Visit:____

Sex: M / F Date of Birth: _____________________ Age: ________ Height: _____________ Weight: _______________

Home Address: ________________________________ City: _________________________State:______ Zip: __________

Who may we thank for referring you? ____

FAMILY INFORMATION:

Mother's Name: _____________________________________ Father's Name: ____________________________________

Do one or both parents have custody? ____

Mom Home Phone #: _________________________________ Dad Home Phone #:_______________________________

Mom Cell #: ____ Dad Cell #: _______________________________________

Parent's Marital Status: Married _________ Single _________ Divorced ________ Widowed __________

List Ages of Other Children in Family: ____

PAYMENT INFORMATION:

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Yes / No

If you have health insurance that may cover chiropractic care, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name: ____________________________________ DOB: _________________ SSN#: ______________________

Insurance Company Name: ___________________________________ Phone#: __________________________________

Insurance Company address to send claims: ____

Employer: _______________________________ Group #: ___________________ Insured ID#:_____________________

PEDIATRIC HISTORY

ANSWER THE QUESTIONS THAT APPLY TO THE GROWTH AND DEVELOPMENT OF YOUR CHILD.

Y or N Was this child born at home?

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Y or N Were forceps or a vacuum extractor used? C-section? __________ Breech delivery? ____________

Y or N Can your child sit unsupported?

Y or N Is your child crawling yet?

Y or N Is your child walking yet? At what age did your child start to walk? ______________months

Y or N Have you noticed a foot turned in or out? ____

Y or N Do you have any other concerns about your child's growth & development? ______________________

____

HEALTH HISTORY

Y or N Has your child any health problems? Infections? ____

Y or N Has your child had any other illnesses? ____

Y or N Is your child presently receiving any medications? ____

Y or N Has your child recently been vaccinated? ______________ Any reactions? ________________________

Y or N Is your child allergic to any medications? ____

FAMILY HISTORY

Do you have family history of:

Y or N Heart Trouble

Y or N Cancer

Y or N Nervous conditions

Y or N Depression

Y or N Inherited disease

LIFE STYLE INFORMATION

DIET

Breast feeding this child? _____________ Are you bottle feeding this child?_________

What is his/her favorite food? ____

What foods does she/he dislike? ____

SLEEPING HABITS

Any problems with bed- time? ____

What position does he/she sleep in? ______________________ Hours Total: _______

Explain: ____

____

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CONSENT FOR CHIROPRACTIC CARE

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter (name) ____ as the doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent/Guardian's Name (Printed) ____

Parent/Guardian Signature: ____

Date: ______________________

CONSENT TO TREATMENT OF MINOR

I, __________________________, Parent or Legal Guardian of ______________________________, a minor child, hereby authorize to consent to any x-ray, examination, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

I agree that these provisions will remain in effect until I provide written revocation to Mohr Chiropractic.

Name of Child: _________________________________
Date of Birth: __________________________________

Printed Name of Parent/Guardian: ____________________________________
Signature of Parent/Guardian: ____
Date: ____________________________

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Mohr Chiropractic P.C., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

PATIENT ACKNOWLEDGEMENT OF NON-COVERED SERVICES

Under your health care plan, you are financially responsible for copayments, coinsurance, or deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. This may include, but is not limited to, Vitamins & Supplements,

Supports, Strapping, and Maintenance Care. Your signature below indicates that you have been advised of this information and that you agree to pay for any non-covered services according to your insurance contract.

Patient/Guardian Signature:_________________________________ **Date:**____________________

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand that parents or guardians are responsible for all fees and services rendered for treatment for myself and/or child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing claims with my insurance company does not relieve me from my responsibility for the payment of all charges.

____
____
____
____
Address of Parent/Guardian

____ ____________________________
Signature of Patient, Parent, or Guardian **Date**

____ ____________________________
Printed name of Patient, Parent, or Guardian **Relationship to Patient**

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Patient Acknowledgement and receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name ________________________________
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy at their request of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is also available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this ______ day of __________________________ , 20_____

By ____
Patient's Signature

If patient is a minor or under guardianship order as defined by State law:

By ____
Signature of Parent or Guardian