



### Patient Information

(Children 10 & under)

Child's Full Name \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Email\* \_\_\_\_\_ \* Your email will NOT be shared with any 3d parties and is used for occasional office announcements and promotions.

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ Carrier \_\_\_\_\_

Please provide carrier for reminder text messages

Primary Contact  Cell  Home  Yes  No

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Female  Male

Emergency Contact: \_\_\_\_\_ Emergency Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### Insurance or Private Pay Information

Type of Insurance:  Private Ins.  Medicare  Auto Ins.  Worker's Comp  Other \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's Birthdate \_\_\_\_\_ Is Patient covered by another insurance?  Yes  No

Secondary Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Birthdate: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

### ASSIGNMENT/AUTHORIZATION/RELEASE

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Advanced Chiropractic of Milford all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

**Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account: \_\_\_\_\_

X \_\_\_\_\_ DATE: \_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian (if minor)

# Health Questionnaire

## Current Complaints

Reason for visit today?: \_\_\_\_\_

When did symptoms start? \_\_\_\_\_ How often are symptoms experienced? (Circle one) Constantly Frequently Occasionally

Describe symptoms? (Circle all that apply): Sharp/ Dull/ Stiff/ Tight/ Aching/ Spasms/ Throbbing / Stabbing/ Shooting/ Burning/ Cramping/ Tingling/ Numbness/ Other \_\_\_\_\_

Rate pain based on face below:



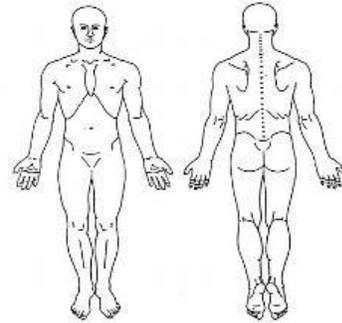
What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Does the condition interfere with any of the following (Circle all that apply): Sleep/ Getting in or out of bed or chair/ Personal care/ Travel/ Work/ Recreation/ Lifting/ Walking/ Standing/ Daily Routine/ Social Activities/ Exercise/ Other: \_\_\_\_\_

Describe location of problem and draw on diagram.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Have you (child) seen a chiropractor before?  Yes  No How long ago? \_\_\_\_\_

## Medical History

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please list any current medications and/or supplements: \_\_\_\_\_

Please list/describe any serious injuries or diagnoses (broken bones, seizure disorder, etc): \_\_\_\_\_

\_\_\_\_\_

Family History (list all major diseases such as cancer, heart problems, bone diseases and the relation to the child):

\_\_\_\_\_  
\_\_\_\_\_

Habits:

Caffeine (soft drinks)	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Heavy	<input type="radio"/> None
Exercise	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Heavy	<input type="radio"/> None
Sleep	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Heavy	<input type="radio"/> None
Water	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Heavy	<input type="radio"/> None
Salty Foods	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Heavy	<input type="radio"/> None
Sugary Foods	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Heavy	<input type="radio"/> None
Artificial Sweeteners	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Heavy	<input type="radio"/> None
Stress	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Heavy	<input type="radio"/> None

**Additional comments you would like the doctor to know:** \_\_\_\_\_

### **Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_ (parent/guardian name) understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I give permission for the following person/people to have full disclosure of my child's appointments and/or medical records:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

### **Financial Policy**

#### **Insurance Coverage**

Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. We will accept your insurance in any of the plans that we are providers with. Certain insurance companies will only allow a particular number of visits per year and/or per diagnosis code. If your insurance company denies your care in total and/or partial with regards to the amount of visits necessary for the treatment of your condition, you will be responsible for the remainder of the balance.

**It is our office policy to collect either a co-pay/co-insurance or an estimated insurance deductible at the time of visit.**

**It is our policy that all appointments must be canceled 24 hours prior to scheduled time other than for weather related cancellations. Anyone canceling appointments with less notice, regrettably, will be charged a \$35.00 fee for the appointment. If we are not in the office a message on our answering machine will do. THIS IS A POLICY WE DO ENFORCE.**

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

**Informed Consent**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me by the Doctor of Chiropractic of Advanced Chiropractic and/or any other Doctor of Chiropractic, who now or in the future treats me while employed by, working or associated with, or serving as back-up for the Doctors of Chiropractic named below, including those working at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fracture, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent for to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

**Chiropractic Consent to evaluate and adjust a minor child:**

I, \_\_\_\_\_ (Parent/guardian name) being the parent or legal guardian of \_\_\_\_\_ (child's name) have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
Printed Name of parent/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Witness