BACKBONE
Wellness Center

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PEDIATRIC INTAKE FORM (BIRTH TO 12 YEARS)

Patient Information:

First Appointment date: ________________

Name ____

Address ____
Street City State Zip Code

Social Security # _______________________________________ Sex: Male / Female

Birth date _____________________ Age __________

Parent / Guardian Information:

Name ____

Home # ( ) __________________ Work # ( ) _____________________ Cell # ( ) _____________________

E-Mail Address ____@___________________________________

Preferred Method of Contact: ☐ E-Mail ☐ Postal Mail ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Is your child adopted? ☐ Yes ☐ No

Child's Care Team:

Has your child been checked by a Doctor of Chiropractic? ☐ Yes ☐ No

If yes, please provide the name of the office & doctor ____

Were x-rays taken? ☐ Yes ☐ No

Who is your medical pediatrician? ____

Prenatal History:

Did you have any complications and when? ____

Did you smoke during pregnancy? ☐ Yes ☐ No

Did you consume alcohol? ☐ Yes ☐ No

Did you take medication? ☐ Yes ☐ No

If yes, reason for the medication? ____

Did you have ultrasound during pregnancy? ☐ Yes ☐ No If yes, how often? _________________

Birth History:

Place of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Other ___________________

Provider: ☐ Midwife ☐ Ob-Gyn ☐ Other _____________________

Were pain medications used? ☐ Yes ☐ No

Was labor induced? ☐ Yes ☐ No

If yes, why? ____

Type of Birth: ☐ Vaginal ☐ C-Section

What position did you deliver in? ☐ Squatting ☐ On Back ☐ Hands and knees ☐ Other _____________

If C-Section, reason: ____

Birth trauma? ☐ Doctor Assisted ☐ Twisting and or Pulling ☐ Vacuum Extraction ☐ Forceps

APGAR score: birth_______/10 5-minutes__________/10 ☐ Unsure

Did your child have a misshaped skull/head? ☐ Yes ☐ No

Were there purple markings on the face? ☐ Yes ☐ No

Medical History:

Did you breastfeed your child? ☐ Yes ☐ No

If yes, did/does your child prefer one breast over the other? ☐ Yes ☐ No

If yes, which side? ☐ Right ☐ Left

Does your child have any food allergies?

If yes, please list ____

Has your child been immunized? ☐ Yes ☐ No

If yes, did you child have any negative reaction to the vaccinations? ☐ Yes ☐ No

If yes, was the reaction reported? ☐ Yes ☐ No

Has your child ever had any surgeries? ☐ Yes ☐ No

If yes, please elaborate ____

Has your child been on antibiotics? ☐ Yes ☐ No

If yes, how often and what for? ____

Is your child currently taking any medication? ☐ Yes ☐ No

If yes, please list ____

Is your child currently taking any vitamins? ☐ Yes ☐ No

If yes, please list ____

How would you rate your child's diet: ☐ Well Balanced ☐ Average ☐ High sugar/processed foods

Does your child consume artificial sweeteners: ☐ Yes ☐ No

Fluoridated water? ☐ Yes ☐ No

Number of hours your child sleeps: _____ hours per day Sleep quality? ☐ Good ☐ Fair ☐ Poor

Baby/Toddler (0-4):

Have any of the following occurred:

☐ Play in a Johnny Jumper ☐ Frequent crying spells ☐ Tumble down stairs ☐ Involvement in MVA

☐ Fall out of crib ☐ Fall off playground equipment ☐ Fall from a changing table ☐ Tonsillitis

☐ Frequent Ear Infections ☐ Reaction to Vaccines ☐ Frequent fevers ☐ Frequent diarrhea

☐ Constipation ☐ Sleeping Problems ☐ Repeated infections/colds ☐ Colic

☐ (+ or -) weight gain ☐ Other (please explain) ______________________________

Child (5-12):

Does your child participate in any of the following?

☐ Soccer ☐ Football ☐ Gymnastics ☐ Karate

☐ Hockey ☐ Lacrosse ☐ Basketball ☐ Dance

☐ Wrestling ☐ Baseball/Softball ☐ Volleyball ☐ Tennis

☐ Swimming ☐ Rugby ☐ Gymnastics ☐ Other ________________

Have any of the following occurred:

☐ Fall from a tree ☐ Fall of a bicycle ☐ Sports accident ☐ Car accident

☐ Stomach pains ☐ Scoliosis ☐ Bed Wetting ☐ Fall on playground

☐ Hyperactivity/Autism ☐ Learning difficulties ☐ Asthma ☐ Allergies

☐ Leg/Knee pains ☐ Other (please explain) ______________________________

Which of the above bothers your child the most? ______________________________

When did it begin? ______________________________

Is it getting worse? ☐ Yes ☐ No

Is the pain: ☐ Constant ☐ Intermittent ☐ Cyclic

Affect on activity: ☐ Not at all ☐ Somewhat ☐ Always

Patient Informed Consent

I, ______________________________, the parent / guardian of the patient, consent to the treatment(s) provided by this clinic. I understand that my child's condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to the child's exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see my child receive treatment at the clinic or overhear discussions of his/her condition or insurance. I consent to others perceiving the interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Parent / Guardian Signature ______________________________

HIPAA PATIENT CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. <u>You have the right to review our Notice before signing this Consent and you are advised to do so</u>. This authorization for release of information covers the period of healthcare from ___________________, 20___ to ___________________, 20___.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands and agrees that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **<u>WILL NOT</u>** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by:

____
Printed Name – Parent or Guardian

____
Signature of Parent or Guardian

____
Date

____
Name of Patient

Witness:

____
Printed Name – Clinic Representative

____
Signature Date

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, BackBone shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_________________________________ _________________________________

PATIENT NAME INSURED'S SIGNATURE

____

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to BackBone all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____________________________________ _____________________________

SIGNATURE OF INSURED/GUARDIAN DATE