



**PEDIATRIC PATIENT INFORMATION**  
**PLEASE PRINT**

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

Full Name \_\_\_\_\_ Called Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_  
 Parents Name \_\_\_\_\_ Called Name \_\_\_\_\_  
 Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 How did you hear about our office? \_\_\_\_\_

**CLAIM INFORMATION:**

Is your condition due to:  An Auto Accident  A Personal Injury  A Work Injury  Other  
 Type of Claim:  Cash  Insurance  Personal Injury  Worker's Comp  Medicare  Medicaid  
 If you have Insurance:  
 Relationship to Insured?  Self  Spouse  Other  Child  Spouse: \_\_\_\_\_  
 Insured's SSN  Same as above SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_

**HEALTH CARE AUTHORIZATIONS:**

*(Please Cross Out Any Permission You Would Like to Revoke)*

- A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- B. I give permission to Alliance Chiropractic Center to use my address, phone number, email and clinical records to contact me with birthday cards, holiday related cards, information about treatment alternatives, office seminar dates, patient appreciation dates or other health related information such as newsletters.
- C. I give permission to Alliance Chiropractic Center to use my name and clinical records to display my photos or x-rays and use my testimonial and experience in an effort to increase the public's awareness of chiropractic.
- D. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.
- E. I understand that my travel card (Daily Visit Chart) contains protected health information and that I should keep it in my possession and upside down to prevent this information from being seen by another patient.
- F. I authorize Alliance Chiropractic Center to take any x-rays the doctor determines will be beneficial to my case during the course of my care. I also recognize that if I am a female it is my responsibility to notify the doctor if I am pregnant or it is possible that I am pregnant.
- G. I am giving Alliance Chiropractic Center permission to use and disclose my protected health information in accordance with the directives listed above.
- H. I am giving Alliance Chiropractic Center permission to contact other health care providers on my behalf to discuss treatment recommendations and co-management of my health care problems.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges: The right to view the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

**RIGHT TO REVOKE AUTHORIZATION:**

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Alliance Chiropractic Center. This AUTHORIZATION is requested by Alliance Chiropractic Center for its own use/disclosure of PHI.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# PLEASE PRINT

## Current Health Conditions

Purpose of this visit \_\_\_\_\_

Other Doctors your child sees \_\_\_\_\_

Medicines your child takes on a regular basis \_\_\_\_\_

## Past Health History

Major Surgeries \_\_\_\_\_

Childhood diseases \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Has your child ever been diagnosed with: Asthma  yes  no Allergies  yes  no ADD/ADHD  yes  no

Has your child ever missed more than a week of school due to illness or injury?  yes  no

Reason \_\_\_\_\_

Has your child ever had previous Chiropractic care?  yes  no

Doctor's name and approximate date of last visit \_\_\_\_\_

## Pediatric Trauma

*The vast majority of our patients have experienced literally dozens of impacts that could cause spinal problems. The following questions help us discover several of yours.*

What was your child's birth like? \_\_\_\_\_

How long did labor last? \_\_\_\_\_ Were you induced?  yes  no C-section?  yes  no

Nerve block / epidural?  yes  no Was there any pulling on the head?  yes  no

*47% of all children fall on their head by the age of one and they have at least 200 more major falls by the age of 5 years old.*

When was the most recent fall? \_\_\_\_\_ Any other falls / injuries that you can remember?

What sports or recreational activities does s/he do? \_\_\_\_\_

When was the most recent stress, strain, or injury while doing these activities? \_\_\_\_\_

Has your child been involved in a motor vehicle accident as a passenger?  yes  no

Briefly describe: \_\_\_\_\_

Any treatment received? \_\_\_\_\_

Are there any other health concerns you would like to let the doctor know about?

Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_