Queensbury Family Chiropractic

PEDIATRIC HISTORY FORM

To help us serve you better, please complete the following information.
We look forward to coaching you to build better health for you and your family.

PERSONAL INFORMATION:

Name: _____ Age:_____ DOB: _____

Address: _____ City/State/ Zip: _____

Parent/Guardian Name(s): _____

Address: _____ City/State/ Zip: _____

Home Phone #: (___)____-_____ Work #: (___)____-_____ Cell #: (___)____-_____

Best Time To Contact: _____

Parent/Guardian Email Address: _____@_____.com

Would you like to receive our Free Wellness E-Newsletter? Yes No

Male: ___ Female: ____ Height: _____ Weight: _____

Reason for consulting our office? Wellness Evaluation:____ or Chief Complaint:_____

Who may we thank for referring you to our office?_____

Your Child's HEALTH Profile

Check any of the following conditions your child has suffered during the past 6 months:

☐ Ear Infections
☐ Asthma/Allergies
☐ Growing/Back Pain
☐ Digestive Problems
☐ Bed Wetting
☐ Seizures
☐ ADD/ADHD
☐ Car Accident
☐ Recurring fevers
☐ Temper Tantrums
☐ Headaches
☐ Colic
☐ Scoliosis
☐ Chronic Colds
☐ Other_____

Family History: _____
_____

Previous Chiropractor: _____
Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____ Last Visit Date: _____
Reason: _____

Number of doses of antibiotics your child has taken in the last 6 months: _____

Number of doses of antibiotics your child has taken in his/her lifetime: _____

Number of doses of prescription Medicines your child has taken in the last 6 months: _____

Number of doses of prescription Medicines your child has taken in his/her lifetime: _____

List any Supplements your child has taken in the last 6 months: _____

List any Supplements your child has taken in his/her lifetime: _____

Your Prenatal History

Name of Obstetrician/Midwife: _____

Describe Complications during pregnancy (if any): _____
_____

Number of Ultrasounds during pregnancy/delivery (if any): _____

List any Medications taken during pregnancy/delivery (if any): _____

List any Cigarette/Alcohol use during pregnancy/delivery (if any): _____

Location of birth (circle): Hospital Birthing Center Home Other: _____

Intervention (circle any that apply): Forceps Vacuum Extraction C-Section: Emergency/Planned

Your Child's Feeding History

Was child Breast Fed: Yes No If Yes, how long: _____

Was child Formula Fed: Yes No If Yes, how long: _____ Type: _____

Introduced to solids at _____ months. Introduced to cow's milk at _____ months.

List any known food/juice allergies or intolerances: _____
_____

Your Child's Developmental History

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (Neuro-spinal interference).

At what age was your child able to:

Respond to Stimuli _____
Respond to Visual Stimuli _____
Hold Head Up _____
Sit Up _____
Cross Crawl _____
Stand Alone _____
Walk Alone _____

According to The National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (a bed, changing table, stairs, etc.). Was this the case with your child: Yes No

Is or has your child been involved in any high impact or contact type sports (football, soccer, gymnastics, baseball, cheerleading, martial arts, wrestling, etc.) Yes No List: _____
_____

Has your child ever been involved in a motor vehicle accident: Yes No Describe: _____
_____

Has your child ever been seen on an emergency basis: Yes No Describe: _____
_____

Other traumas not described above: _____
_____

Has your child had any surgeries: Yes No Describe: _____

Menarche: Yes No Age: _____

Childhood Diseases:

☐ Chicken Pox: Age _____
☐ Rubella: Age _____
☐ Rubeola: Age _____
☐ Mumps: Age _____
☐ Whooping Cough: Age _____
☐ Other: _____ Age: _____

Thank you for filling out this form. It is your first step to Optimal Health!
Return this to our staff along with your Driver's License

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name: _____ Signature: _____ Date:_____

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Print Name: _____ Signature: _____ Date:_____

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT

Privacy Notice

TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice of Queensbury Family Chiropractic will be provided to me upon my request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Queensbury Family Chiropractic to provide treatment to me, and also necessary for Queensbury Family Chiropractic to obtain payment for that treatment and to carry out its health care operations Bruce Steinberg, DC has further explained my right to obtain a copy of this Privacy Notice prior to signing this Consent, and has encouraged me to read this Privacy Notice prior to my signing this Consent.

2. Queensbury Family Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.

3. I understand that, and consent to, the following appointment reminders or communications that will be used by Queensbury Family Chiropractic.

a.) a postcard mailed to me at the address provided by me; and

b.) Telephoning my home or cellular phone and leaving a message on my answering machine or with the individual answering the phone.

4. Queensbury Family Chiropractic may use and/or disclose my PHI to the third party (which includes information about my health or condition and the treatment provided to me) in order to treat me and obtain payment for that treatment, and as necessary for Queensbury Family Chiropractic to conduct its specific health care operations.

5. I understand that I have a right to request that Queensbury Family Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Queensbury Family Chiropractic is not required to agree to any restrictions that I have requested. If Queensbury Family Chiropractic agrees to a requested restriction, then the restriction is binding.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocations shall not apply to the extent that Queensbury Family Chiropractic has already taken action in reliance on this consent.

7. I understand that if I revoke this Consent at any time, Queensbury Family Chiropractic has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above in this Privacy Notice and contained in the enclosed Releases, then Queensbury Family Chiropractic will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed) Signature of Individual _____

Signature of Legal Guardian/if a minor Relationship _____

Date Signed: ____/____/_____ Witness: _____

Releases

I hereby request and consent to receive chiropractic services, including, but not limited to, adjustments, various manual and mechanical procedures, various modes of therapy and X-rays, or me (or for the patient named below, for whom I am legally responsible) by any licensed Doctors of Chiropractic who now or in the future treat me while employed by, working with, are associated with, or providing coverage services for this office (collectively known as the “Treating Doctor(s)”), including those working at any office associated with the Treating Doctor(s) (collectively known as the “Staff”.) I authorize the Treating Doctor(s) and Staff to request medical records as needed from any source.

Initials: _____

I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize and assign any benefits to be paid directly to the Doctor’s Office. Any payments will be immediately credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. **Initials**: _____

In consideration of services rendered, I hereby assign to the provider of the services and his assignees so much of my third party insurer, first party no-fault automobile or Worker’s Compensation insurance benefits and rights, attendant thereto, as shall equal the full amount of the bill for such services and the provider or his assign may secure in my name. **Initials**: _____

Kindly furnish my doctors, insurance company, attorney and any other involved parties or their representatives all information you may have regarding my condition while under your treatment or observation, including but not limited to the history obtained, X-ray, testing, physical findings, diagnosis and prognosis. **Initials**: _____

I have had the opportunity to review and understand a Privacy Notice. I understand that I have the right to review the complete policy prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. There are no restrictions, unless explicitly noted here. **Initials**: _____

I have read and understood the above information:

Patient /Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

Financial Policy & Profile

PAYMENT IS DUE AS SERVICES ARE RENDERED

Our office is a cash practice, all services are due when rendered, unless other arrangements have been made prior to treatment.

Method of Payment:

Cash: _____ Check: _____ Credit Card: _____ HAS: _____ Insurance: _____

Group Insurance

Patients are responsible for payment at the time of their visit. As a courtesy we will verify your insurance. Verification is not a guarantee of payment. The insurance contract is between the patient and the insurance company. We do accept assignment once verification of coverage has been made. You are responsible for any unpaid balance by your insurance company.

Insurance Company: _____ Policy #: _____

Group #: _____ Insurance Phone: _____

Primary Insured: _____ You/Spouse/Other _____

Medicare

The doctor is a non-participating Medicare provider. Medicare patients are required to pay cash as services are rendered and we will submit your claims as a courtesy to you. Medicare patients must present their Medicare card at the onset of treatment. The only treatment Medicare covers is acute care.

Workers Compensation and Personal Injury

We are a cash practice, if you have been injured; you are still required to pay at the time of service. You will be reimbursed by your insurance carrier.

My Certification

(Assignment & Release)

I certify that the above information is correct and I request services. I certify that I, and/or my dependant(s), assign directly to Dr. Bruce P. Steinberg 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 they are paid by insurance.*** I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____/_____/_____

Signature of Patient/Parent or Guardian Date