Chiropractic HEALTH SOLUTIONS
Your Solution to a Healthy Lifestyle
Dr. Brenda Ilaser

Pediatric Intake Form

2 months to 2 years

Child's Legal Name: _____ Today's Date: _____/_____/_____

Address: _____ City: _____ ST:___ Zip: _____

Home Phone: _____ Parent's Cell Phone: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M F Social Security #:_____

Mother's Name: _____ Father's Name: _____

Sibling's Name(s) and ages: _____ _____

_____ _____

How did you hear about our office? _____

Please select any of the applicable reasons that you are pursuing chiropractic care for your child:

____ He/she is continuing care from another chiropractor.
____ I recently had my spine checked and see the value in examining my child for subluxations.
____ I'm concerned about his/her health and am looking for answers.
____ He/She has a specific condition that concerns me. Please explain:_____
_____
____ I have been told that chiropractic care will benefit my child, however, I am not sure how it will help.

Is this visit the result of an auto injury? _____ If yes, when was it?_____/_____/_____

Do you have family members with similar health concerns?_____ If yes, who? _____

Has your child seen another doctor for the issue he/she is being seen today? _____

If yes, please provide name of doctor:_____

INSURANCE INFORMATION

Insurance company:_____

Policy #:_____ Policy Holder:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Protected Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%. The patient understands and agrees to allow this chiropractic office to use their Protected Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Protected Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Protected Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: _____

Guardian's Signature Authorizing Care _____ Date _____

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PRENATAL HISTORY

Was the patient adopted?_____ Were there complications during the pregnancy?_____ If yes, explain:

_____

Were ultrasounds performed during pregnancy? _____ If yes, how many?_____

Were medications/drugs/caffeine taken during pregnancy? _____ If yes, please list type and amount:

_____

Were cigarettes or alcohol used during pregnancy? _____ If yes, please list type and amount:

_____

Location of birth: _____ in hospital _____ in birthing center _____ at home

Birth Intervention:

_____ mother induced _____ mother medicated (Pitocin, etc.) _____ forceps _____ vacuum extracted

Were there complications during delivery? _____ If yes, please explain:

_____

Are there genetic disorders/disabilities? _____ If yes, please explain:

_____

HEALTH HISTORY

Does child have any known allergies?_____ If yes, to what? _____

Has your child ever taken antibiotics?_____ If yes, what kind and when? _____

List any current medications: _____

List any past medications:_____

Has child ever had any surgeries?_____ If yes, what surgery and when?_____

Has child been diagnosed with cancer or any other illness?_____ If yes, please explain:_____

_____

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INFANT HISTORY

The following questions are designed to help the doctor provide the best possible care for your child.

NUTRITION

Is your child still being breast fed? Y N If no, for how long was he/she breast fed? _____

If still being breast fed, how much cow's milk does the mother consume each day? _____

Is your child formula fed? Y N Which formula or other milk source?_____

Is your child eating solid food? Y N What foods does his/her diet contain? _____

_____ What is your child's favorite food? _____

Does your child have any feeding difficulties? Y N _____

Does your child have any digestive disturbances? Y N _____

Does your child have any food allergies? Y N _____

Does your child have any persistent or intermittent skin rashes? Y N _____

Is your child receiving any vitamin supplements? Y N _____

TRAUMA

Has your child had any recent falls or trauma? Y N _____

If yes, describe the trauma and the date it occurred. _____

Has your child ever fallen down the stairs or fallen from any height? Y N _____

Has your child ever been in a motor vehicle collision or near miss? Y N _____

Has your child ever had a bone fracture or joint dislocation? _____

Has your child had any other trauma or injuries? Y N _____

Does your child ever bang his/her head repeatedly against a wall, bed or other object? Y N_____

Do you have any other concerns you wish to discuss? _____

Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: Medicare____ Medicaid____ Group Health Plan____ Other____

2. Insured's ID

Number_____

3. Patient

Name:_____

4. Insured

Name:_____

5. Insured date of birth: _____ SSN: _____ Male _____ Female ____

6. Insured employer name or School name:_____

City_____ State_____ Zip_____ Tel #_____

7. Insured's Address (if same as patient put "same"):_____

City_____ State_____ Zip_____ Tel #_____

8. Patient Status: Single Married Other Employed Full-time Student Part-time Student

9. Is the condition we are treating related to current or previous employment? Yes____ No____

10. Is the condition we are treating related to an auto accident? Yes____ No____

11. Is the condition we are treating related to another type of accident? Yes ____ No____

12. Is there another health benefit plan? Yes____ No____ If yes, list: _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed:

_____Date:_____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed:

_____Date:_____

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes___ No___

2. Are you entitled to Medicare because of End Stage Renal Disease? Yes___ No___

3. Is the illness or injury the result of an accident or illness that occurred at work? Yes___ No___

4. Is this illness or injury the result of an accident or other injury? Yes___ No___

5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes__ No__

6. Are you entitled to any benefits under the Federal Black Lung Program? Yes___ No___

7. Do you have a Medicare Medigap Policy? Yes___ No___ Name of Company_____

8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes___ No___