Welcome To Wagner Family Chiropractic, S.C. Pediatric Intake Form

Patient Information

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐M ☐F Age_____ Birthdate_____

Weight:_____Height:_____

Patient SS#_____

Names of Parents/Guardians:_____

_____

Whom may we thank for referring you?_____

_____

Doctor Information

Previous Chiropractor_____
Date of Last Visit_____/_____/_____
Reason_____
Name of Pediatrician_____
Date of Last Visit_____/_____/_____
Reason_____

Insurance

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned Certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially respondsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Phone Numbers

Home_____Work_____Ext_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____

Home Phone_____

Work Phone_____Ext_____

Accident Information

Is condition due to an accident? ☐Yes ☐No Date____

Type of accident ☐Auto ☐Home ☐Other_____

Have you made a report of your accident?

☐Yes ☐No With Whom?_____

Attorney Name (if applicable)_____

_____

Patient Condition

Purpose For Contacting Us?_____

Other Health Problems_____

Check any of the following conditions your child has suffered from during the Past SIX Months:

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

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months_____, Total During His / Her Lifetime_____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months_____, Total During His / Her Lifetime_____ List:_____

Vaccination History_____

Feeding History

Breast Fed ☐Yes ☐No, How Long_____

Formula Fed ☐Yes ☐No, How Long_____ Type_____

Introduced to: Solids at_____Months

Cows Milk at_____Months

Food/Juice Allergies or Intolerances ☐Yes ☐No

List_____

Childhood Diseases

Chicken Pox	☐Yes ☐No	Age_____
Rubella	☐Yes ☐No	Age_____
Rubeola	☐Yes ☐No	Age_____
Mumps	☐Yes ☐No	Age_____
Whooping Cough	☐Yes ☐No	Age_____
Other	☐Yes ☐No	Age_____

Developmental History

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to sound

_____ Respond to Visual Stimuli

_____ Hold Head Up

_____ Sit Up

_____ Cross Crawl

_____ Stand Alone

_____ Walk Alone

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

Explain_____

Is/has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? ☐No ☐Yes, Time of Involvement_____

_____

Has your child ever been involved in a Car Accident? ☐No ☐Yes, Explain:_____

Has your child ever been seen on an Emergency Basis? ☐No ☐Yes, Explain:_____

Other Traumas not described above? ☐No ☐Yes, Explain:_____

Prior Surgery: ☐No ☐Yes, Explain:_____

First menses: ☐No ☐Yes, Age of:_____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed:_____ Witnessed:_____Date:_____/_____/_____

Wagner Family Chiropractic, S.C.
N110 Brux Road
Appleton, WI 54915
920-968-0464 www.wagnerchiropractic.net

INFORMED CONSENT TO TREATMENT AND RESPONSIBILITY AGREEMENT

Please print your name: _____

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used.

Possible Risks: As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord . A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare", statistically less often than complications from taking a single aspirin tablet.. There has not been a single reported injury in our clinic since its inception in 2004.

Other Treatment Options which could be considered may include the following:

1. *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
2. *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

I understand payment is expected at the time of the visit. Any other arrangements, including direct insurance billing, payment plan or deferral, must be made in writing through the front desk. Verbal agreements are not acceptable. I hereby authorize the release of my medical records and other information necessary to process insurance claims. Monthly statements will include a $5.00 statement fee on all balances not paid within 30 days. I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, are charged directly to me and that I am personally responsible for payment. I understand that even if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable.

I realize a notice of 24 hours is encouraged for canceled appointments. I understand that my time slot is only for me and that by missing an appointment without canceling means that someone in need is unable to be seen. Therefore, canceling as early as possible is greatly appreciated to allow others my time slot.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____	_____	_____
Signature of Individual/Legal Representative/Guardian*	Relationship to Patient	Date

Wagner Family Chiropractic, S.C.

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920-968-0464

www.wagnerchiropractic.net

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

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

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
    a) A postcard mailed to me at the address provided by me; and
    b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
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 revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice 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 and contained in the Privacy Notice, then the Practice 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.

_____ _____

Signature of Individual/Legal Representative* Date

_____

Relationship to Patient

*Attorney-In-Fact, Guardian, Parent if a minor