# Pediatric Health Record

## Patient Information

Child's Name: _____ Child's Preferred Name: _____

Reason for visit: _____

Sex: _____ Date of Birth: _____ Age: _____ Child's SS number: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Predominant language used at home: _____ Who may we thank for referring you? _____

mail _____

## Contact Information

Please check the box next to who the primary contact will be.

Mother/Guardian #1 Name: _____ Father/Guardian #2 Name: _____

Mother/Guardian #1 Phone: _____ Father/Guardian #2 Phone: _____

Parent's Marital Status: Married Single Divorced Widowed

## Primary Insured

Full Name: _____ Social Security Number: _____

Date of Birth: _____ Drivers License Number: _____

## Payment Information

Please read and sign our Patient Financial Responsibility Policy.

## Consent to Treat

Being the parent or legal guardian of this child, I hereby authorize this office, Opp Family Chiropractic P.A., and its doctors to examine and administer care to my son/daughter named, _____ as the examining/treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent/Guardian Printed Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. For an example; the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of the PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a Privacy Official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our Privacy Official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations; the chiropractic physician has the right to refuse to give care.

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I agree to allow Opp Family Chiropractic to leave voice messages on my phone containing personal information.

☐ Yes ☐ No

Check all phone numbers that apply:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Other:_____

I agree to allow Opp Family Chiropractic to send me emails containing personal information.

☐ Yes ☐ No

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Printed Name_____ Signature _____

Date_____ Relationship to Patient (if under age 18):_____

Patient Name:_____ Patient D.O.B.: _____

**Name:**_____ **Date:**_____ **D.O.B.:**_____

# Pediatric Pre-Exam Information

## Family Medical History

Please check if any blood relatives to the patient had any of the following illnesses. Blood relatives include mother, father, sibling, paternal grandmother, maternal grandmother, paternal grandfather or maternal grandfather.

- ☐ Allergy, Asthma or Eczema
- ☐ Cancer
- ☐ Diabetes or Low Blood Sugar
- ☐ Heart Trouble
- ☐ High Blood Pressure / Stroke
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Intellectual/Developmental Disability
- ☐ Scoliosis
- ☐ Ulcers
- ☐ Other:_____

## Pregnancy

Please check any areas that applied to the patient's mother during her pregnancy.

- ☐ Alcohol
- ☐ Allergic Reactions
- ☐ Attitude - Mostly Depressed
- ☐ Attitude - Mostly Happy
- ☐ Carried to Full Term
- ☐ Caffeine: Cola
- ☐ Caffeine: Coffee
- ☐ Caffeine: Chocolate
- ☐ Caffeine: Tea
- ☐ Caffeine: Other
- ☐ Chiropractic Care
- ☐ Complications
- ☐ Excessive Weight Loss
- ☐ Excessive Weight Gain
- ☐ Hospitalization
- ☐ Immunization
- ☐ Mental Trauma
- ☐ Medications
- ☐ Other Pain
- ☐ Prenatal Classes
- ☐ Physical Injury
- ☐ Prenatal Care
- ☐ Recreational Drugs
- ☐ Smoking
- ☐ Toxic Exposure
- ☐ Vitamins / Minerals
- ☐ Other:_____

## Labor and Delivery

Please check any areas that applied to the patient's mother during labor and delivery.

- ☐ Caesarian
- ☐ Complications
- ☐ Fetal Monitor Used
- ☐ Forceps
- ☐ Greater than 12 hours
- ☐ Hospital
- ☐ Home Birth
- ☐ Medications
- ☐ Premature Delivery
- ☐ Vacuum Extraction
- ☐ Other:_____

The duration of the pregnancy was _____ weeks.

The apgar score at birth was _____. The apgar score at five minutes was _____.

The length at birth was _____ . The weight at birth was _____ .

Please check any problems the patient had at birth:

- ☐ Breathing
- ☐ Coloring
- ☐ Crying
- ☐ Choking
- ☐ Jaundice
- ☐ Nursing
- ☐ Sleeping
- ☐ Other:_____

Please check if any item(s) applied to the patient at birth:

- ☐ Artificial Feeding
- ☐ Circumcision
- ☐ Erythromyocin
- ☐ Medication
- ☐ Surgery
- ☐ Vitamin K
- ☐ Other:_____

**Name:**_____ **Date:**_____ **D.O.B.:**_____

**Nutrition**

Please check if the patient has received any of the following items:

| | | |
|---|---|---|
| ☐ Breast Milk | ☐ Juice: Fruit | ☐ Sweets |
| ☐ Commercial Formula | ☐ Juice: vegetable | ☐ Vitamins |
| ☐ Cow's Milk | ☐ Medications | ☐ Other: _____ |
| ☐ Goat's Milk | ☐ Solid Foods | |

**Immunization**

Please list any immunizations the patient had received along with the date it was received and any reactions observed:

| Immunization | Date | Reaction |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Illnesses**

Please list any illness(es) the patient has had along with the date and any treatments received.

| Illness | Date |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Family Physician**

Name of pediatrician: _____

Date of last exam: _____

**General System Review**

Has your child ever been unconscious or had a convulsion? ☐ Yes ☐ No

Any problems with the eyes, including vision? ☐ Yes ☐ No

Has your child ever been cyanotic? (turned blue) ☐ Yes ☐ No

Does your child tolerate exercise? ☐ Yes ☐ No

Any recurring problem with vomiting, diarrhea, constipation or stomach pain? ☐ Yes ☐ No

Does your child's stools look or smell abnormal? ☐ Yes ☐ No

If yes, please explain: _____

Any unusual problem on passing urine or any unusual frequency? ☐ Yes ☐ No

Any unusual smell or appearance of urine? ☐ Yes ☐ No

Does your child complain of any extremity or back pain? ☐ Yes ☐ No

Do you notice a limp or unusual gait pattern? ☐ Yes ☐ No

Any allergies, eczema, hay fever, hives, asthma or drug reactions? ☐ Yes ☐ No _____

Does your child suffer from any other problems? ☐ Yes ☐ No _____

## Patient Financial Responsibility Policy

Opp Family Chiropractic appreciates your confidence in choosing us to provide for your healthcare needs. We are committed to providing you with the best possible care for your total body wellness. The treatment you have elected to participate in includes a financial responsibility on your part. The responsibility obligates you to ensure payment in full for our services. Contact your insurance company to determine what is covered and what is not. You are ultimately responsible for payment of any services and care received at Opp Family Chiropractic, whether they are covered by your insurance company or not. Be sure to bring your insurance card to each visit. Always notify our office of any changes to your insurance. And lastly, be prepared to pay any portions your insurance company does not cover.

### Co-Pays and Deductibles

If your insurer requires you to pay a co-pay or deductible, please be aware of the amount of your co-pay or deductible at the time of service. You will be asked to pay all co-pays or deductibles at the time of service. If you do not pay your co-pay or deductible at the time of service, we will bill you and may charge you a reasonable service fee to offset the cost of sending you a statement. Full payment is due within seven (7) days of the date it was mailed or emailed to you.

### Cancellation / No Show Policy

When you make an appointment, we reserve time specifically for you. Unfortunately, when a patient does not show for their scheduled appointment, another patient loses an opportunity to be seen. Therefore, if you need to cancel or re-schedule, you are asked to notify us as soon as possible, but no later than 24 hours in advance. Appointments cancelled without 24 hours notice may be assessed a cancellation fee of $25. Habitually cancelling appointments may cause us to ask you to seek another chiropractor for your healthcare needs.

### Failure to Meet Financial Responsibility

If you fail to meet the financial obligations agreed upon in this policy and acknowledgment, your outstanding balance will be sent to a collection agency and the balance will have to be paid before receiving further treatment. Your future status with this office will be considered at that time and may lead to being discharged from care at Opp Family Chiropractic. If you have any questions, please contact the billing department.

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### Patient Acknowledgment

I have read and understand Opp Family Chiropractic's Patient Financial Responsibility Policy. I agree to assign insurance benefits to Opp Family Chiropractic whenever necessary. I authorize Opp Family Chiropractic to release information to a collection agency or attorney in the event I do not fulfill my financial responsibilities. I understand that if I fail to meet my financial obligations to Opp Family Chiropractic, then I will be responsible for all costs for reasonable collection and/or attorney fees, if applicable. I expressly authorize Opp Family Chiropractic to charge any outstanding balance, due to co-pays, deductible or non-covered services, on my credit/ debit card pursuant to the terms I agreed to in this Acknowledgement and the Patient Payment Authorization I signed.

I would like Opp Family Chiropractic to (check all that apply):

☐ Mail my billing statement to:

Name: _____

Street Address: _____

City, State, Zip Code: _____

☐ Email my billing statement to:

Email address: _____

Printed Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____

Patient Name: _____ Patient D.O.B.: _____

**Patient Payment Authorization**

## Explanation of Automated Recurring Payment option

Opp Family Chiropractic offers an automated payment option to our patients for their convenience. If you (a patient or payer on behalf of a patient) return this completed Patient Payment Authorization, we will automatically charge your credit/debit card for any outstanding balance due to co-pays, deductibles or non-covered services.

By my signature below, I authorize Opp Family Chiropractic P.A. to process my debit/credit card for 100% of the patient's outstanding balance in full if after seven (7) days of the receipt of an emailed or mailed billing statement a balance remains owing for co-pays, deductibles or non-covered services. I understand I may revoke this authorization by giving my notice in writing to Opp Family Chiropractic.

This authorization is to remain in full force and effect until all amounts owed related to the treatment rendered to the patient are paid in full, or until I cancel this authorization. To cancel, I must notify Opp Family Chiropractic in writing and give reasonable opportunity to act.

I agree that Opp Family Chiropractic, in its sole discretion, may terminate this agreement if my account should lack sufficient funds for payment. In the event Opp Family Chiropractic is unable to secure funds from my bank account or credit card for any reason, I may be charged for further collection action that may be undertaken to the full extent provided by law.

Check here if you would like a phone call before we charge your account ☐

Check here if you would like us to charge your account without a phone call ☐

Name on Card: _____

Billing Street Address: _____

Billing City, State, Zip: _____

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover ☐ Other: _____

Card Number: _____

Expiration Date: _____ CVV Code: _____

Patient Name: _____ Patient D.O.B.: _____

Cardholder Printed Name: _____ Cardholder Signature: _____