PATIENT APPLICATION FORM:
CHILD

WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. We are a very unique team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. Because of this specialized approach, we may not accept your child as a patient until we are absolutely certain we know the cause of their condition; perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

____

PATIENT NAME

____

DATE COMPLETED

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Confidential Pediatric History Form

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To better serve you, please complete the following information. We look forward to working with you! Thank You!

Date: ______________________________ Referred By: ____

Child's Name: ____ Phone Number: ______________________

Do you have other immediate household family members who are patients here? Y N

If yes, please list them ____

Address: __________________________________ City: ________________ State: _____ Zip: __________

Sex: M F Weight: ________ Height: _______ S.S.#: __________________ Birth Date: ______________

Name of Parents/Guardians: _________________________________ Phone Number: ____________________

Email Address of Parents/Guardians: _________________________________

Purpose for Contacting Us? ____

Other Doctors seen for this condition: Y N If yes, please list doctor's name and prior treatments: __________

____

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

- ○ Ear infections
- ○ Asthma/Allergies
- ○ Colic
- ○ Scoliosis
- ○ Digestive problems
- ○ Bed Wetting
- ○ Seizures
- ○ ADHD
- ○ Auto Accident
- ○ Chronic Colds
- ○ Recurring Fevers
- ○ Temper Tantrums
- ○ Headaches
- ○ Growing/Back pains
- ○ Other: ________________ ____________________

Family History: ____

Previous Chiropractor: ______________________________ Date of Last Visit: ________________ Reason: __________________

Were you satisfied? Y N Why? ____

Previous / Current Pediatrician: ______________________________ Date of Last Visit: ____________ Reason: __________________

Number of doses of antibiotics your child has taken:

a) During the past six months: ____

b) Total during his/her life: ____

Number of doses of other prescription medications your child has taken:

c) During the past six months:____

d) Total during his/her life:____

Vaccination History: ____

Feeding History

Breast Fed: Y N If yes, how long?__________________ Formula: Y N If yes, how long:____________________

Introduced to solids at _____ months. Cow's milk at _____ months. Food/juice allergies or tolerances: Y N

If Yes, please list:____________________ Other allergies or tolerances: Y N If Yes, please list:________________

Number of Hours Sleeping per Night: ___________ Quality of Sleep: Good ________ Fair ________ Poor ________

Prenatal History:

Name of obstetrician/midwife: ______________________ Pediatrician / Family MD: ______________________

Birth intervention: Forceps________ Vacuum Extraction: _______ Caesarian Section: _______ Emergency or Planned?: ______________

Ultrasounds during pregnancy? Y N If yes, how many:_______________________________________

Medications during pregnancy/delivery? Y N If Yes, please list them:________________________________

Cigarette/alcohol use during pregnancy? Y N

Childhood Diseases:

Chicken Pox: Age:_____ Rubeola: Age:_____ Whooping Cough: Age:_____

Rubella: Age:____ Mumps: Age:_____ Other: ______________________

According to the National Safety 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? Y N – If yes, please explain: ______________________

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Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). Y N If Yes, Please list: ____

____

Has your child ever been involved in a car accident? Y N If yes, please explain: ______________________________

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

I hereby authorize **Liberty Chiropractic - A Wellness Way Affiliate** 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: ______________________________ Relationship to Patient: ____________________ Date: ____________________

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? ❑ Yes ❑ No

Patient's Signature ____ Date ______________