

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? _____

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 responsible 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 _____

Doctor Information

Previous Chiropractor _____

Date of Last Visit ____/____/____

Reason _____

Name of Pediatrician _____

Date of Last Visit ____/____/____

Reason _____

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:

<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Chronic Colds	<input type="checkbox"/> Headaches
<input type="checkbox"/> Asthma/Allergies	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> ADHD	<input type="checkbox"/> Recurring Fevers	<input type="checkbox"/> Growing/Back Pains
<input type="checkbox"/> Colic	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Car Accident	<input type="checkbox"/> Temper Tantrums	<input type="checkbox"/> 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 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? 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.

N9654 County Road N Ste. #3

Appleton, WI 54915

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



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INFORMED CONSENT TO TREATMENT AND RESPONSIBILITY AGREEMENT

Please read each section carefully. You will be furnished with a copy of this form for your own records.

I, _____, hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above-named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgment for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. Although adverse events are extremely rare with chiropractic I understand that with any treatment there are risks. These risks include, but are not limited to fracture, stroke, and even death. I intend this consent to cover the entire course of treatment.

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. Monthly statements will include a 1.5% monthly interest charge on all balances not paid within 30 days.

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. (Please call 920-968-0464 to cancel appointments.)

I hereby authorize the release of my medical records and other information necessary to process insurance claims.

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.

Signature of Individual/Legal Representative*

Date

Relationship to Patient

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