

PEDIATRIC PATIENT INFORMATION
PLEASE PRINT

Date: ___ / ___ / ___

Full Name _____ Called Name _____
Address _____ City _____ State _____ Zip _____
SSN _____ - _____ - _____ Sex ____ Age ____ DOB _____ School _____
Parents Name _____ Called Name _____
Phone _____ Work Phone _____ Cell Phone _____
Email _____ Spouse's Name _____
How did you hear about our office? _____

CLAIM INFORMATION:

Is your condition due to: An Auto Accident A Personal Injury A Work Injury Other
Type of Claim: Cash Insurance Personal Injury Worker's Comp Medicare Medicaid
If you have Insurance:
Relationship to Insured? Self Spouse Other Child Spouse: _____
Insured's SSN Same as above SSN _____ - _____ - _____ DOB _____

HEALTH CARE AUTHORIZATIONS:

(Please Cross Out Any Permission You Would Like to Revoke)

- A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- B. I give permission to Lake Norman Health and Wellness to use my address, phone number, email and clinical records to contact me with birthday cards, holiday related cards, information about treatment alternatives, office seminar dates, patient appreciation dates or other health related information such as newsletters.
- C. I give permission to Lake Norman Health and Wellness to use my name and clinical records to display my photos or x-rays and use my testimonial and experience in an effort to increase the public's awareness of chiropractic.
- D. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.
- E. I understand that my travel card (Daily Visit Chart) contains protected health information and that I should keep it in my possession and upside down to prevent this information from being seen by another patient.
- F. I authorize Lake Norman Health and Wellness to take any x-rays the doctor determines will be beneficial to my case during the course of my care. I also recognize that if I am a female it is my responsibility to notify the doctor if I am pregnant or it is possible that I am pregnant.
- G. I am giving Lake Norman Health and Wellness permission to use and disclose my protected health information in accordance with the directives listed above.
- H. I am giving Lake Norman Health and Wellness permission to contact other health care providers on my behalf to discuss treatment recommendations and co-management of my health care problems.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges: The right to view the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Lake Norman Health and Wellness. This AUTHORIZATION is requested by Lake Norman Health and Wellness for its own use/disclosure of PHI.

Patient Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

PLEASE PRINT

Current Health Conditions

Purpose of this visit _____

Other Doctors your child sees _____

Medicines your child takes on a regular basis _____

Past Health History

Major Surgeries _____

Childhood diseases _____

Hospitalizations _____

Has your child ever been diagnosed with: Asthma yes no Allergies yes no ADD/ADHD yes no

Has your child ever missed more than a week of school due to illness or injury? yes no

Reason _____

Has your child ever had previous Chiropractic care? yes no

Doctor's name and approximate date of last visit _____

Pediatric Trauma

The vast majority of our patients have experienced literally dozens of impacts that could cause spinal problems. The following questions help us discover several of yours.

What was your child's birth like? _____

How long did labor last? _____ Were you induced? yes no C-section? yes no

Nerve block / epidural? yes no Was there any pulling on the head? yes no

47% of all children fall on their head by the age of one and they have at least 200 more major falls by the age of 5 years old.

When was the most recent fall? _____ Any other falls / injuries that you can remember?

What sports or recreational activities does s/he do? _____

When was the most recent stress, strain, or injury while doing these activities? _____

Has your child been involved in a motor vehicle accident as a passenger? yes no

Briefly describe: _____

Any treatment received? _____

Are there any other health concerns you would like to let the doctor know about?

Parent or Guardian: _____ Date: _____