BACK IN LINE CHIROPRACTIC CENTER

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CHILDREN'S HEALTH HISTORY FORM

Today's Date_____

Name _____ Age _____ Date of Birth _____

Gender O Male O Female Height _____ Weight _____

Home Address _____City _____ State _____

Zip _____ Names and Ages of Siblings_____

PARENT A

Name

_____

Phone (____) _____

E-mail _____

Employer_____

Phone (_____) _____

PARENT B

Name

_____

Phone (_____) _____

E-mail _____

Employer _____

Phone (_____) _____

Whom may we thank for referring you to our office? _____

REASON FOR YOUR VISIT

What concerns do you feel we can address for your child?

_____

_____

Related to: O Sports O Auto O Fall O Chronic O Home Injury O Other _____
Please describe how these concerns are affecting your child's quality of life.

_____

_____

Check any being affected O School O Exercise/Sports O Walking O Playing O Sleep O Attention/Focus

O Communication O Eating O Daily Routine

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply:

O Symptomatic relief of pain or discomfort

O Correction of the cause of the problem as well as relief of symptoms

O Prevention of future problems θ Healthier spine and nerve system

O Optimal health on all levels

OTHER_____

PATIENT HISTORY

During pregnancy, did the mother experience any significant illnesses, difficulties, or trauma?

O YES _____ O NO

Take any drugs/medications?

O YES _____ O NO

Smoke or consume alcohol? O YES O NO

O Home birth O Hospital birth O Vaginal O Water Birth O Caesarean

Was the delivery premature? O No O Yes Weeks _____

Weight _____ Approximately how long did labor last? _____ Hours

Was labor artificially induced? O No O Yes

Was it determined that the child was breech or otherwise mispositioned? O No O Yes

The birth process can be traumatic to a baby's spine and cause interference to the nervous system.

Please check which, if any, of the following were administered during labor and birth:

O Epidural O Forceps O Vacuum O Medications _____ O Pitocin O Episiotomy

O Manual traction of the neck

Please check all that apply to the baby's status immediately after birth:

O Jaundice O Respiratory Problems O Broken bones _____

O Feeding problem O Displaced joints O Other conditions _____
APGAR Score _____ Was the baby breastfed? O No O Yes

For how long? _____

Have you chosen to vaccinate your child? O No O Yes.

If yes, please check all vaccinations the child has received and at what age they were administered:

O DPT _____ O MMR _____ O Polio _____ O Chicken Pox _____

O Hepatitis _____ O Flu _____ O Covid-19 _____

Please describe all vaccine(s) reactions _____

_____

Please check all that apply and give any necessary details:

O Child exposed to second-hand smoke.

O Has taken antibiotics. Explain _____

O Currently taking medication. Explain _____

O Currently taking supplements. Explain _____

O Has allergies. Explain _____

What treatments have you used? _____

Please check all that apply to your child and give any necessary details:

O Uncoordinated/Accident prone. _____

O Has been hospitalized. _____

O Had a severe trauma. _____

O Been in an automobile accident. _____

O Has fractured a bone or dislocated a joint. _____

O Has/had a chronic illness. _____

O Has had surgery. _____

What physical activities does your child participate in?

_____

_____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

O Academic pressure O Loss of a loved one O Bullying O Relocation O Lifestyle change

O Parents' divorce O Loss of a pet O New sibling

Does your child have difficulty interacting with schoolmates or friends? O Yes O No

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? O Yes O No Explain: _____

_____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? O Yes O No

Name of D.C. _____

Reason _____ How long? _____

Date of last visit _____ Why was care stopped? _____

Have you consulted, or do you regularly consult any of the following providers for your child? (Check all that apply)

O Medical Physician O Naturopath O Acupuncturist O Homeopath

O Massage Therapist O Psychotherapist O Energy Healer

O Other Reason_____

FAMILY HEALTH HISTORY

THIS FORM ISTO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

Child's Name _____ Date _____

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					
OTHER					
OTHER					
OTHER					

FINANCIAL RESPONSIBILITY

Child's Name: _____ Date of Birth: _____

Social Security: (last 4-digits) _____

Contact in case of emergency: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER:

_____

Name of Insured_____ Insured's Date of Birth _____
Insured's Social Security Number _____-_____-_____

NAME OF SECONDARY INSURANCE CARRIER:

_____

Name of Insured_____ Insured's Date of Birth _____
Insured Social Security Number: _____-_____-_____

Insurance Policies and Fee Schedule

- Consultation- includes practice member history. This service is complimentary
- Assessment (new or established practice member) - includes one or more of the following: postural evaluation, range of motion, orthopedic / neurological exam, motion and/or static palpation, leg check.
- Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand or instrumentation. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place.
- X-rays- Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care.

***Fees for services vary depending on the individual's needs and recommendations.

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from Back In Line Chiropractic Center ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my, and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my insurance benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date

INFORMED CONSENT

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. You should note:

1.While rare, some patients may experience short-term aggravation symptoms, rib fractures or muscle and ligament strains or sprains because of manual therapy techniques.

2.There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes some neurological impairment and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.

3.There are rare, reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused by spinal adjustments or chiropractic treatment.

I acknowledge I have discussed or had the opportunity to discuss with my Chiropractor the nature and purpose of Chiropractic treatment in general and my treatment (including spinal adjustment) as well as the contents of this consent.

I consent to the Chiropractic treatments recommended to me by my Chiropractor, Dr. Peter Marciante, including spinal adjustment. I intend this consent to apply to all my present and future Chiropractic care.

Dated this ____ day of _____ 20____ Doctor Initials _____

Patient Signature _____ Print Name _____

I hereby also request and consent to the performance of: (sign)

_____Acupuncture (I understand the methods may include but are not limited to acupuncture needling, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine and nutritional counseling.

_____Massage Therapy

_____Physical Therapy

Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. Arbitration Agreement is included in your Notice of Privacy Practices Package.

Missed appointments:

Dr. Marciante strives to provide excellent service and quality care. Therefore, we feel that it's only fair for all appointments to be kept, please provide at least 24 hrs. notice of cancellation, to timely accommodate another patient. **The cancellation fee is $40.**

I agree and fully understand the missed appointment policy. _____(Initial)

Notice of HIPPA Privacy forms:

I have read Back in Line Chiropractic Center's Notice of Privacy Practices prior to signing this consent. Back in Line Chiropractic Center reserves the right to revise its notice of Privacy Practices at any time.

By signing this form, I am consenting Back in Line Chiropractic Center's use and disclosures of my PHI to carry our TPO.

Signature _____ Date _____

X-Ray Examination (for females only):

I am aware that the radiation exposure may be harmful to an unborn child. To the best of my knowledge, I am not pregnant at the time. I agree to diagnostic x-ray examinations as requested by Dr. Marciante. _____(Initial)

Photographs and Films:

I further agree to the taking of photographs, films, or other materials showing the condition of my mouth or my treatment for the purpose of documentation, my education and diagnosis, as well as for insurance purposes. _____(Initial)

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms. _____(Initial)

_____ _____

Signature of patient or responsible party/ Date Signature of witness/ Date

_____ _____

Name of patient or responsible party Name of witness