Falite Family Chiropractic
Pediatric New Patient Questionnaire

Date:_____

Child's First Name:_____ Middle Initial:_____ Last Name:_____

Date of Birth:_____ Age:_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Parent's Work Phone:_____

Cell Phone:_____ email:_____

Mother's Name:_____ Mother's DOB:_____

Father's Name:_____ Father's DOB:_____

Names & Ages of Siblings:_____

Reason for consulting our office:_____

Referred By:_____ Relationship:_____

Previous Chiropractic Care? Y / N With whom:_____ Last Visit:_____

CIRCLE APPROPRIATELY:

Birth Place: Home / Birth Center / Hospital
Type: Vaginal / C-Section
Procedures: Forceps / Vacuum Extraction
Was delivery long? Y / N Was delivery difficult? Y / N Was labor induced? Y / N
Epidural? Y / N Pain medication? Y / N Was baby breech/in utero-constraint? Y / N
Was baby breast fed? Y / N Duration:_____

CIRCLE APPROPRIATELY:

Which Contact Sports does your child participate in:
Soccer / Football / Gymnastics / Cheerleading / Karate / Basketball / Dance /
Other:_____

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child?
_____YES _____NO Comments:_____

List any other falls or accidents:_____

List date and year of any surgeries or hospitalizations:_____

OVER

Check any of the following conditions your child has suffered from:

___ Ear Infections
___ Sinus infections
___ Headaches
___ Asthma / Allergies
___ Chronic Colds
___ Recurring Fevers
___ Neck Pain
___ A.D.D. / A.D.H.D.
___ Temper Tantrums
___ Head-Banging
___ Growing Pains
___ Scoliosis
___ Depression
___ Mid-back Pain
___ Fatigue
___ Seizures
___ Colic
___ Digestive Problems
___ Diarrhea / Constipation
___ Bed-Wetting
___ Low Back Pain

___ Other:_____

MEDICATION

How many rounds of antibiotics has your child taken in the last 6 months?_____ Lifetime?_____

Present prescription drugs:_____

Past prescription drugs:_____

Over-the-counter drugs (Tylenol, cough syrup, laxatives, etc.):_____

FINANCIAL INFORMATION

Are you planning on using some type of insurance? Yes / No

***If you will be using insurance, please permit our office to copy your insurance card.

Primary Insured's Name:_____

Primary Insured's SSN:_____ Primary Insured's DOB:_____

Primary Insured's Employer:_____

What method of payment will you be using? cash / check / credit card

By signing below, I understand that I am ultimately responsible for the payment of the balance due for my child's care in this office.

Person responsible for account:_____

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AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Falite Family Chiropractic and its doctors to administer care as they deem necessary to my son/daughter.

Signature:_____Relationship:_____Date:_____

HEALTH CARE AUTHORIZATION FORM

You are being provided with a copy of this Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of your Protected Health Information (PHI) that will occur during your treatment, payment of your bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes your rights and the duties of the Chiropractor with respect to your protected health information. By signing below, you are giving permission to Falite Family Chiropractic (FFC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to FFC to use my address, phone number, email and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives and/or other health related information.
- If FFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to FFC to have my name on a sign-in sheet.
- I give permission to FFC to use my photograph on their patient picture bulletin board and/or other marketing materials such as their brochures, website and ads in print media.
- I give permission to FFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochures, on their website or in ads in print media.
- I give FFC permission to treat me in a semi-private room where other patients are also being treated. 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.

By signing this form you are giving FFC permission to use and disclose your protected health information in accordance with the directives listed above. The use of this format is intended to make your experience with our office more efficient and productive, as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of your care at Falite Family Chiropractic, plus 7 years or until revoked by yourself.

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 the Privacy Official of FFC. The written notice must contain the following information: your name, Social Security number and date of birth; a clear statement of your intent to revoke this AUTHORIZAITON; the date of your request; and your signature. The revocation is not effective until it is received by the Privacy Official. This AUTHORIZATION is requested by FFC for its own use/disclosure of PHI. *(Minimum necessary standards apply)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, FFC will not refuse to provide treatment, however, it will not be possible for FFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since FFC will be unable to contact me 3) all contact with FFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.* I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN:_____ DOB:_____ Today's Date:_____

Patient's name (please print):_____

Signature:_____ Relationship to Patient:_____