Mohr Chiropractic
7390 Business Center Drive
Avon, Indiana 46123
(317)272-7000

PEDIATRIC NEW PATIENT INFORMATION

PATIENT INFORAMTION:

Child's First Name: _____ Last Name:_____

Sex: M / F Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Home Address: _____ City: _____State:_____ Zip: _____

Who may we thank for referring you? _____

Reason for Visit:_____

When did symptoms begin?_____

No particular conditions or symptoms – Just seeking general health: _____ (Only check if no symptoms)

FAMILY INFORMATION:

Mother's Name: _____ Father's Name: _____

Do one or both parents have custody? _____

Mom Home Phone #: _____ Dad Home Phone #:_____

Mom Cell #: _____ Dad Cell #: _____

Parent's Marital Status: Married _____ Single _____ Divorced _____ Widowed _____

List Ages of Other Children in Family: _____

PAYMENT INFORMATION:

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Yes / No
If you have health insurance that may cover chiropractic care, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.
Insured's Name: _____ DOB: _____ SSN#: _____

Insurance Company Name: _____ Phone#: _____

Insurance Company address to send claims: _____

Employer: _____ Group #: _____ Insured ID#:_____

PEDIATRIC HISTORY

ANSWER THE QUESTIONS THAT APPLY TO THE GROWTH AND DEVELOPMENT OF YOUR CHILD.

Y or N Was this child born at home?

Y or N Were forceps or a vacuum extractor used? C-section? _____ Breech delivery? _____

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Y or N Can your child sit unsupported?

Y or N Is your child crawling yet?

Y or N Is your child walking yet? At what age did your child start to walk? _____months

Y or N Have you noticed a foot turned in or out? _____

Y or N Do you have any other concerns about your child's growth & development? _____

_____

HEALTH HISTORY

Y or N Has your child any health problems? Infections? _____

Y or N Has your child had any other illnesses? _____

Y or N Is your child presently receiving any medications? _____

Y or N Has your child recently been vaccinated? _____ Any reactions? _____

Y or N Is your child allergic to any medications? _____

FAMILY HISTORY

Do you have family history of:

Y or N Heart Trouble
Y or N Cancer
Y or N Nervous conditions
Y or N Depression
Y or N Inherited disease

Explain: _____

LIFE STYLE INFORMATION

Breast feeding this child? _____ Are you bottle feeding this child?_____
What is his/her favorite food? _____
What foods does she/he dislike? _____
SLEEPING HABITS
Any problems with bed- time? _____
What position does he/she sleep in? _____ Hours Total: _____

_____
_____

CONSENT FOR CHIROPRACTIC CARE

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter (name) _____ as the doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent/Guardian's Name (Printed) _____

Parent/Guardian Signature: _____Date:_____

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CONSENT TO TREATMENT OF MINOR

I, _____, Parent or Legal Guardian of _____, a minor child, hereby authorize to consent to any x-ray, examination, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

I agree that these provisions will remain in effect until I provide written revocation to Mohr Chiropractic.

Name of Child: _____
Date of Birth: _____

Printed Name of Parent/Guardian: _____
Signature of Parent/Guardian: _____
Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Mohr Chiropractic P.C., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

PATIENT ACKNOWLEDGEMENT OF NON-COVERED SERVICES

Under your health care plan, you are financially responsible for copayments, coinsurance, or deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. This may include, but is not limited to, Vitamins & Supplements, Supports, Strapping, and Maintenance Care. Your signature below indicates that you have been advised of this information and that you agree to pay for any non-covered services according to your insurance contract.

Patient/Guardian Signature:_____ **Date:**_____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand that parents or guardians are responsible for all fees and services rendered for treatment for myself and/or child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing claims with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____
_____
_____
_____
Address of Parent/Guardian

_____ _____
Signature of Patient, Parent, or Guardian **Date**

_____ _____
Printed name of Patient, Parent, or Guardian **Relationship to Patient**

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Patient Acknowledgement and receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name _____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy at their request of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is also available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____ , 20_____

By _____
Patient's Signature

If patient is a minor or under guardianship order as defined by State law:

By _____
Signature of Parent or Guardian