East Stadium Chiropractic Wellness Center

Child Health Form

To be filled out by parent or guardian. Please print clearly and fill in completely.

Print Name _____ Circle: Male / Female Date ____/____/____
Street Address _____ Apt.# _____ City _____
State ____ Zip _____ Phone ( )_____ Date of Birth ____/____/____ Weight: ____ Height: ____
Right handed ❒ Left Handed ❒ Name(s) of Parents / Guardians: _____

Health History:

Give reason(s) for seeking chiropractic care: _____

_____

Describe any health problems, including how long your child has had them: _____

_____

Is your child under the care of any other doctor? Yes ❒ No ❒ If Yes, please list the doctors your child is seeing, the conditions being treated for, and any progress: _____

_____

List any current Medications: _____
List any past surgeries & dates: _____
List any past accidents & dates: _____
Number of doses of Antibiotics your child has taken: Last six months: ____ Total during lifetime: _____
Vaccination History: _____

Chiropractic History:

Has your child been to a Chiropractor before? Yes ❒ No ❒ If yes, Doctor's Name _____
Are other family members under chiropractic care? - Yes ❒ No ❒ Who? _____

Prenatal History:

Complications during pregnancy? Y / N List: _____
Complications during delivery? Y / N List: _____
Ultrasounds during pregnancy? Y / N Number: _____
Medications during pregnancy / delivery? Y / N List: _____
Birth Intervention?: ___Forceps ___Vacuum extraction ___Cesarean section
APGAR Scores (if known): _____ Birth weight: _____ Birth Length: _____
Cigarette or alcohol use during pregnancy? _____
Genetic disorders or disabilities: Y / N List: _____

Feeding History:

Breast Fed: Y / N How long: _____ Formula Fed: Y / N How Long? _____
Introduced: solids at _____ months, cow's milk at _____ months
Food / Juice allergies or intolerances: Y / N List: _____

Please describe any other information you feel would assist us in the care of your child: _____

_____

_____

Print Parent's Name: _____
Parent's Signature: _____ **Date:** _____

I authorize East Stadium Chiropractic to initiate examination and care for the minor listed above as I am this child's parent or legal guardian.

Waiver of X-Rays

I acknowledge that the doctors of East Stadium Chiropractic have recommended that x-rays be taken. These recommendations were made so that a complete study and analysis may be made of my present problem or illness. I do not feel that my present problem or illness is serious enough to warrant the use of x-rays. Therefore, you are hereby authorized and directed to provide care as best you can without doing a complete study and analysis of my present problem or illness.

Should any untoward effects develop or any further illness or injury develop directly or indirectly as a result of such care, I shall assume full responsibility. In consideration of you treating me at my request without the benefit of a complete study and analysis, I do hereby release the doctors of East Stadium Chiropractic from all causes of action, damages, and liabilities arising by reason of said care. Whether heretofore or hereafter occurring, and whether known or unknown between the parties hereto.

Name	Signature	Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and is accepted as a patient for such care, it is essential for both parties to be working toward the same objectives and understand the methods used in treatment. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of spinal nerve interference. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: Also known as spinal nerve interference; a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This results in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

By signing below I acknowledge that I have read and fully understand the above statements.

Patient Name (Printed)	Signature *(Must be signature of parent or guardian)*	Date

AUTHORIZATION FOR CARE OF A 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 responsible for payment of all fees charged by this office.

Signature _____ Date _____

(Must be signature of parent or guardian)

PAYMENT FOR SERVICES

Insurance policies vary greatly in what services they will pay for. Some policies are more complete than others, and cover more services. Our office staff will try to contact your insurance company on your first visit, or soon after to find out what services are covered by your contract. We do this in a sincere attempt to inform you of your expected health care costs.

WE CANNOT BE HELD RESPONSIBLE FOR WRONG INFORMATION PROVIDED TO US BY YOUR INSURANCE COMPANY!

1. We will be glad to prepare, and send your insurance claims for you. When we send in your claims we will "accept assignment". This means that your insurance company will pay their portion of your claim directly to our office.

YOU MAY STILL BE RESPONSIBLE FOR THE FOLLOWING:

- DEDUCTIBLE
  An initial amount in medical expenses that you must pay each year before your insurance begins payment. You will be charged for each visit until your deductible is met.

- CO-PAYMENT
  A percentage, or set dollar amount of all charges. Please pay your ESTIMATED co-payment at the time of service to help us reduce billing costs.

- UNCOVERED SERVICES
  You are responsible for payment of any services not covered by your insurance company. If you have another insurance policy, it may cover services that your first insurance policy does not.

2. Insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

BENEFITS QUOTED BY EAST STADIUM CHIROPRACTIC OR YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF BENEFITS! RESPONSIBILITY FOR PAYMENT RESTS ULTIMATELY WITH YOU!

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, & Discover. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. We will be glad to address any questions about the above information or any concerns regarding your insurance coverage; please do not hesitate to ask us.

By my signature below I acknowledge that I have read the above information, and agree that I am responsible for all costs incurred at East Stadium Chiropractic Wellness Center.

Patient Name (Printed) _____

Signature _____ Date _____

(Under 18 years of age must be signature of parent or guardian)