Chiropractic Preliminary Information - Children

Welcome to our office! It is well known that families who maintain strong, healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.

Child's Legal Name________________________________ Date____________________

Is there a nickname child likes to be called?________________________ Gender: ☐Male ☐Female

Birthdate______________ Age_____ SS#______________ Home Phone______________

Address______________________________ City,State, Zip____________________

Mother's Name____________________ Date of Birth__________ SS#______________

Mother's Employer________________________ Mother's Cell Phone #______________

Father's Name____________________ Date of Birth__________ SS#______________

Father's Employer________________________ Father's Cell Phone #______________

Insurance coverage? ☐No ☐Yes Insurance Carrier______________Subscriber Name______________

1. Who **referred** you to our office? ____________________ How known?____________________

   ☐Office Sign/Drive By ☐Internet ☐Presentation ☐Newspaper ☐Other____________________

2. How many times has your child visited a chiropractor in their lifetime?_____ How long ago?______________

3. What is child's **MAIN complaint** (reason for visit)?________________________________

4 How **long** have they had this condition?______________ **When** did this episode start?______________

5. What do you feel **caused** the condition?________________________________

6. Is condition related to an **accident or injury**? ☐No ☐Yes ☐Auto ☐Work ☐Home ☐Other Date__________

7. How **often** are symptoms present? ☐Rare (10%) ☐Occasional (25%) ☐Intermittent (50%) ☐Frequent (75%) ☐Constant (100%)

8. **Describe discomfort**: ☐Sharp ☐Soreness ☐Throbbing ☐Tingling ☐Dull ☐Tightness ☐Stabbing ☐Annoying ☐Burning

   ☐Spasm ☐Ache ☐Weakness ☐Numbness ☐Deep ☐Shooting ☐Other______________

9. Does the **pain radiate**? ☐No ☐Yes If yes, to where?________________________________

10. Since the problem began, is it: ☐Getting worse ☐Getting better ☐Staying the same

11. **Rate the intensity** of child's symptoms on a scale of 1-10, both at rest and with activity. Circle your answers:

    (At Rest) No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

    (With Activity) No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

12. What **relieves** child's symptoms? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Movement/exercise ☐Ice ☐Heat

    ☐Lying Down ☐Other ________________________________

13. What **aggravates** child's symptoms? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Movement/exercise ☐Lifting

    ☐Lying Down ☐Other ________________________________

14. Has child had **other care** for this condition? ☐No ☐Yes Describe care:________________________

15. Has child had this **condition previously**? ☐No ☐Yes When?__________ Frequency?______________

16. **Activities of daily life affected** by this condition: ☐Bending ☐School Work ☐Getting in/out of car ☐Sitting ☐Standing ☐Lifting ☐Personal Care ☐Sleeping ☐Walking ☐Household Chores ☐Other____

17. List all **past surgeries**:____

18. What **drugs/medications** does child take?____

19. Below is a listing of symptoms and conditions. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present	Symptom	Past	Present
Neck Pain	☐	☐	Headaches	☐	☐	Sinus conditions	☐	☐
Shoulder pain	☐	☐	Dizziness	☐	☐	Allergies/Asthma	☐	☐
Arm/Elbow pain	☐	☐	Fainting Spells	☐	☐	Cancer	☐	☐
Hand pain	☐	☐	Convulsions	☐	☐	Stroke	☐	☐
Upper back pain	☐	☐	General prolonged fatigue.	☐	☐	Excessive weight loss/gain	☐	☐.
Lower back pain	☐	☐	High blood pressure	☐	☐	Skin condition	☐	☐
Pain in upper leg or hip	☐	☐	Heart condition	☐	☐	Arthritis	☐	☐
Pain in lower leg or knee	☐	☐	Respiratory condition	☐	☐	Diabetes	☐	☐
Pain in ankle or foot	☐	☐	Digestive problems	☐	☐	Prostate Condition	☐	☐
Jaw pain	☐	☐.	Kidney/bladder problems	☐	☐	Condition of uterus/ovaries	☐	☐
Swelling of joints	☐	☐	Menstrual problems	☐	☐	Other, Please List:.______________________		
Stiffness of joints	☐	☐	Breast soreness/lump	☐	☐	________________________________		

20. Has child had any **previous accidents or trauma**? Type & Date:____

21.The birth process may cause subluxations in your child's spine. Type of birth: ☐Vaginal ☐C-Section

22. During delivery, what medications were used? ☐Epidural ☐Spinal Block ☐Other ___________________________ ☐None

23. Were any of the following used to assist your child's birth? ☐Suction ☐Forceps ☐Dr.'s Hands Other__________________

24. Has your child ever had any reactions following a vaccination? ☐High fever ☐High pitched screaming ☐Seizure ☐Lethargy Other____ ☐Not vaccinated

25. **Female - Pregnancy Release -** I certify that to the best of my knowledge child is **NOT PREGNANT** and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____________________ Patient/Parent Signature____

26. If the doctor feels that chiropractic will help your child, are you willing to follow his recommendations? ☐Yes ☐No

Authorization
I certify that I am the patient or legal guardian of patient listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charge to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Parent/Guardian Signature____ **Date**_______________________________

If child has an **additional complaint (reason for visit)**, please complete the following (**otherwise leave blank**):

1. What is child's **additional complaint** (reason for visit)?____

2. How **long** has child had this condition?____________________ **When** did this episode start?____________________

3. What do you feel **caused** the condition?____

4 Is condition related to an **accident or injury**? ☐No ☐Yes ☐Auto ☐Work ☐Home ☐Other Date________________

5 How **often** are symptoms present? ☐Rare (10%) ☐Occasional (25%) ☐Intermittent (50%) ☐Frequent (75%) ☐Constant (100%)

6. **Describe discomfort**: ☐Sharp ☐Soreness ☐Throbbing ☐Tingling ☐Dull ☐Tightness ☐Stabbing ☐Annoying

☐Burning ☐Spasm ☐Ache ☐Weakness ☐Numbness ☐Deep ☐Shooting ☐Other____________________

7. Does the **pain radiate**? ☐No ☐Yes If yes, to where?__________________________________

8. Since child's problem began, is it: ☐Getting worse ☐Getting better ☐Staying the same

9. Rate the **intensity** of child's symptoms on a scale of 1-10, both at rest and with activity. Circle your answers:

(At Rest) No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

(With Activity) No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

10. What **relieves** child's symptoms? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Movement/exercise ☐Ice ☐Heat

☐Lying Down ☐Other ____

11. What **aggravates** child's symptoms? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Movement/exercise ☐Lifting

☐Lying Down ☐Other ____

12. Has child had **other care** for this condition? ☐No ☐Yes Describe care:______________________________

13. Has child had this **condition previously**? ☐No ☐Yes When?________________ Frequency?____________________

14. **Activities of daily life affected** by this condition: ☐Bending ☐Employment ☐Getting in/out of car ☐Sitting ☐Standing

☐Lifting ☐Personal Care ☐Sleeping ☐Walking ☐ School Work ☐Other__________________________

15. Do you have any **additional complaints** (reasons for visit)? ☐No ☐Yes - Please ask the front desk for additional pages.

Patient Name (printed)__________________________________ Date:__________________________

Signature of Parent/Guardian________________________________ Parent Name Printed________________________

Relationship to patient____

Electronic Health Records Intake Form

In compliance with requirements of the Affordable Care Act

First Name:_________________________________ **Last Name**:____

Email address: ____

Cell Phone #: ____________________________ **Carrier :** ☐Verizon ☐Sprint ☐T-Mobile ☐AT&T ☐_____________

Preferred method of communication for patient reminders: ☐Email ☐ Phone ☐Mail ☐Text Message

DOB: ___________________ **Gender :** ☐Male ☐Female **Preferred Language:** ______________________

Smoking Status: ☐Occasional Smoker ☐Former Smoker ☐Never Smoker (means you have smoked less than 100 cigarettes in lifetime) ☐Heavy Tobacco Smoker ☐Light Tobacco Smoker

CMS requires providers to report both race and ethnicity

Ethnicity : ☐Hispanic or Latino ☐Not Hispanic or Latino ☐ I Decline to Answer

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White ☐ Native Hawaiian or Pacific Islander ☐Other ___________________________ ☐ I Decline to Answer

Are you currently taking any PRESCRIBED medications? ☐NO ☐YES (complete below)

Medication Name	How Many	Dosage (ie. 5 mg)	Frequency (i.e. once a day, etc.)	Route (Pill, Capsule, Syringe, Inhaler, Suppository, etc.)	Date Started

Do you have any medication allergies? ☐NO ☐YES (complete below)

Medication Name	Reaction	Onset Date	Additional Comments

Signature of Parent or Legal Guardian: ____Date:______________________

Print Name:____ Relationship to Patient:_____________________________

Height: ______'________" Weight:____________lbs Blood Pressure: L R S ________ / D________

Acknowledgement of HIPAA Notice of Privacy Practices

I hereby acknowledge that I have received and reviewed a copy of the HIPAA Notice of Privacy Practices from the office of Gary C. Stewart, D.C. (Stewart Family Chiropractic). The HIPAA notice is also available on our website at stewartfamilychiro.com

______________________________ ______________________________ ______________

Name (Printed Please) Signature Date

If you are representing a minor, please list the minor's name(s) and your relationship.

____ ________________

Minor's Name(s) Relationship

Health Information Release - Designation of Relatives, Friends, and Other Caregivers for Healthcare Disclosure

I hereby authorize my Doctor and/or staff of Stewart Family Chiropractic to release any information concerning my condition, chiropractic care, or other healthcare information to persons involved with my healthcare decisions or payment.

I designate the following person(s) listed below as authorized to receive my personal health information. I may change the designees in writing at any time:

Name:________________________________ Relationship:______________________

Name:________________________________ Relationship:______________________

Name:________________________________ Relationship:______________________

__________________________ ____________________________ __________

Name (please print) **Signature of Parent or Guardian of Minor** Date

CONSENT TO CHIROPRACTIC CARE OF MINOR CHILD(REN)

I hereby authorize Dr. Gary C. Stewart, Stewart Family Chiropractic, and whomever he may designate as assistants, to

administer the required care as deemed necessary to ____________________________________

Name(s) of Child(ren)

Signed:____________________________ Printed Name:____________________________

Relationship to Child(ren)__________________________________ Date:____________________

Witnessed by:____________________________

INSURANCE ASSIGNMENT POLICY

This office will assist the patient whenever possible in obtaining their benefits under their insurance policy.

IT MUST BE UNDERSTOOD:

1. Waiting for insurance payment is a courtesy and may be withdrawn at any time.
2. If your insurance carrier sends a payment directly to you, you are required to forward the check (endorsed over to the doctor), plus the explanation of benefits, or pay that amount to Dr. Stewart by personal check, cash, or money order within three business days of receipt or you will be legally responsible for the full amount of the bill. Failure to turn over insurance payments may result in your account being turned over for collection, and you will be responsible for collection fees as well. Please always bring in the explanation of benefits.
3. The patient must stay current with their percentage of responsibility. Payments toward deductible and insurance co-payments are due at the time of service or in advance.
4. If the patient discontinues care for any reason other than discharge by the Doctor, the bill is due and payable in full immediately, regardless of any claims submitted.
5. All deductible amounts must be paid prior to insurance submittal.
6. When this office receives an insurance check, if there is any balance due at that time, the patient will be notified and is required to pay the difference.
7. This office does not promise that an insurance company will pay the fees as charged.
8. In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it does not.
9. This office will not enter into a dispute with an insurance company over reimbursement or the amount of reimbursement. This is the patient's obligation.
10. Insurance assignment may not be accepted until the patient attends the Doctor's Report and Report of Findings.
11. It is the patient's responsibility to resolve any issues (provide missing information, fill out questionnaire, update coordination of benefits, etc.) with the insurance carrier. If the patient fails to resolve any issues with the insurance carrier in a timely fashion and as a result a payment is not issued, patient will be legally responsible for the full amount of the bill.

I HAVE READ AND AGREE TO THE ABOVE INSURANCE ASSIGNMENT POLICY.

Patient/Responsible Party Signature ____ DATE_____________________

Printed Name____

Gary C. Stewart, D.C.
Stewart Family Chiropractic
43 Newark Pompton Turnpike
Riverdale, NJ 07457
(973) 835-5773

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PHYSICIAN

Private, Group, Accident, Medicare and Health Insurance

I hereby authorize and direct my Insurance Carrier(s), including Medicare, private insurance, group, accident, and any other health/medical plan to pay by check (or EFT) made out and mailed directly to:

Gary C. Stewart, D.C.
43 Newark Pompton Turnpike
Riverdale, NJ 07457
(973) 835-5773

If my policy prohibits direct payment to my doctor, then I hereby instruct and direct the check to be made to me and mailed as follows:

C/O Gary C. Stewart, D.C.
43 Newark Pompton Turnpike
Riverdale, NJ 07457
(973) 835-5773

for the professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand and acknowledge that if my insurance carrier sends the payment directly to me, I shall turn over the insurance payment(s) to Stewart Family Chiropractic/Gary C. Stewart, D.C. within three business days or I will be legally responsible for the full amount of the bill. Failure to turn over insurance payments may result in my account being turned over for collection, and I will be responsible for collection fees as well.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance carrier, adjuster, or attorney involved in this case.

______________________________	______________________________
Signature Patient/Responsible Party	Printed Name
______________________________	______________________________
Witness	Date