New Pediatric Patient Intake

It's all about the uniqueness of your child.

PATIENT INFORMATION

Patient Name: ____ Date: _____________________

Preferred Name:____

DOB: ____________________ Age: _____________________ Sex: ____Male ____ Female

Address: _______________________ City: _______________________ State: ______ Zip: ___________

Home #: (______)_______________ Office #:(______)_______________ Cell #:(______)________________

Where do you prefer to receive calls? ___Home ___Office ___Cell ___No preference

Whom may we thank for referring you? ____

RESPONSIBLE PARTY

Name of Person Responsible for Account: ____

Relationship to Patient: ____________________________________ Phone #: (______)_______________

Address: _______________________ City: _______________________ State: ______ Zip: ___________

E-mail____

Name of Employer: ____ Work #: (______)_______________

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _______________________________
Name of Insurance Carrier

and assign directly to Dr. Tyler Molstre all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Carrier and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ______________________________
Signature of Parent, Guardian or Personal Representative Date

____ ______________________________
Print Name of Parent, Guardian or Personal Representative Relationship to patient

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Present Health Challenge(s):

For what health challenge(s) is your child here for?

____

What do you feel is the cause of your child's problem?

____

When did you first notice this sign of body dysfunction?

____

Is this dysfunction getting progressively worse? ___Yes ___No

If yes, why do you think so?

____

Please mark and X for any of the following that apply.

____ ADD/ADHD	____Frequent colds/ congestion	____Upper respiratory Infections	____Asthma
____Ear infections	____Infected/sore Throat	____Tonsillitis	____Laryngitis
____Colic	____Reflux/spitting up	____U-tract infections	____Poor appetite
____Poor digestion/ (constipation/diarrhea)	____Thrush mouth/ Chronic diaper rash	____Eczema/psoriasis/ Other skin rashes	____ADD/ADHD
____Irregular sleep Patterns	____Night terrors	____Bed wetting	____Headache
____Anxiety	____Mood swings	____Bruising	Other____________________

Is there anything else you feel we should know about your child?____

____

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Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form. We ask about family members to determine if the problem may be familial in nature.

	Father	**Mother**	**Spouse**	**Brother**(s)		**Sister**(s)		**Children**		
	Age____	Age____	Age____	Age____	Age____	Age____	Age____	Age___	Age___	Age___
First Name										
Condition										
Allergies										
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										
Other:										

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Certifications and Assignment

This office conforms to the current HIPPAA Guidelines. You may request a copy of our HIPPAA policies at the front desk. Please initial to indicate you have been made aware of its availability ______________________________. I certify that I'm the patient or legal guardian 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 charged 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.

Patient/Guardian Signature____

Date____

Print Name/Patient____