Dakota Chiropractic
making your health a priority

PEDIATRIC
PATIENT INFORMATION

INSURANCE INFORMATION: Please present your insurance card(s) at time of service. If you have primary **AND** secondary insurance please inform the front desk, so there is no discrepancy with your claims.

1 PATIENT DEMOGRAPHICS

CHILD'S FIRST NAME _____ CHILD'S LAST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FUTURE APPOINTMENT TEXT REMINDERS? ◯ Y ◯ N CELL PHONE PROVIDER _____

EMAIL _____ *This will be used to email receipts, for future newsletter mailings or massage specials only. It will not be solicited.*

BIRTH DATE MM|DD|YYYY _____ ◯ M ◯ F GENDER SOCIAL SEC. XXX-XX-XXXX _____

MOTHER'S NAME _____ PHONE _____ SOCIAL SEC. XXX-XX-XXXX _____

FATHER'S NAME _____ PHONE _____ SOCIAL SEC. XXX-XX-XXXX _____

INSURED'S NAME _____ INSURED'S BIRTH DATE MM|DD|YYYY _____

INSURED'S EMPLOYER _____ OCCUPATION _____

HOW DID YOU HEAR ABOUT OUR OFFICE? ◯ GOOGLE ◯ LOCAL BEST ◯ DR. MCCOY ◯ DR. STEEVER

◯ EXISTING PATIENT _____ ◯ ANOTHER PROVIDER _____

2 EMERGENCY CONTACT

FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO PATIENT _____ PHONE _____

PRIMARY DOCTOR/CLINIC _____ PHONE _____

You may be asked to sign a Patient Authorization to Release Information, as we would want to request information from other providers that have participated in your care. This will help insure that we have all information concerning your condition.

AUTHORIZATION FOR CARE OF MINOR

PARENT/GUARDIAN NAME (PRINT) _____ PARENT/GUARDIAN SIGNATURE _____ DATE _____

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PATIENT NAME (PRINT) _____ DATE _____

1. **Purpose for contacting us:** _____

2. **Has your child been treated by anyone for this condition?** ◯ This Office ◯ Medical Doctor ◯ Other ◯ Chiropractor ◯ Physical Therapist

   If yes, please list doctor's name and treatment: _____

3. **Check any of the following conditions your child has suffered from during the past six months:**

   ◯ ADHD ◯ Colic ◯ Headaches ◯ Sleeping Problems
   ◯ Asthma/Allergies ◯ Digestive Problems ◯ Recurring Fevers ◯ Temper Tantrums
   ◯ Bed Wetting ◯ Ear Infections ◯ Scoliosis ◯ Other
   ◯ Chronic Colds ◯ Growing/Back Pains ◯ Seizures _____

4. **Family health conditions/concerns:** _____

5. **Has your child been seen in an emergency room, had a trauma or surgeries?** ◯ YES ◯ NO

   If yes, please list: _____

6. **Has your child been in a car accident?** ◯ YES ◯ NO

7. **Describe your child's temperament:** _____

8. **Does your child go to daycare?** ◯ YES ◯ NO

PRENATAL HISTORY

Name of Obstetrician/Midwife: _____

Complications During Pregnancy? ◯ YES ◯ NO **If yes, please describe** _____

Ultrasounds During Pregnancy? ◯ YES ◯ NO **How many?** _____

Medications During Pregnancy and Delivery? ◯ YES ◯ NO

Please List Medication(s) and Duration: _____ _____

BIRTHING HISTORY

Location of Birth: ◯ Hospital ◯ Birthing Center ◯ Home

Birth Process: ◯ Vaginal ◯ Forceps ◯ Vacuum Extraction ◯ Planned Cesarean ◯ Emergency Cesarean

Birth Complications? ◯ YES ◯ NO **If yes, please describe** _____

At birth, your child was how many weeks? _____

Birth Weight: _____ **Birth Height:** _____ **APGAR Scores:** _____

Genetic Disorder or Disability? ◯ YES ◯ NO **If yes, please list** _____

FEEDING HISTORY

Breast Fed? ◯ YES ◯ NO **Duration:** _____ **Introduction to Solids:** _____ Months

Formula Fed? ◯ YES ◯ NO **Duration:** _____ **Introduction to Cow's Milk:** _____ Months

Food Allergies/Intolerances? ◯ YES ◯ NO **If yes, please list** _____

Wet Diaper: _____ **per day** **Bowel Movements:** _____ **per** ◯ DAY ◯ WEEK

PARENT/GUARDIAN NAME (PRINT) _____ PARENT/GUARDIAN SIGNATURE _____ DATE _____

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FINANCIAL POLICY

1. Please verify your chiropractic benefits with your health insurance company. When our staff calls on your benefits they only give us an outline of benefits, not a guarantee of payment. All benefits are subject to the terms and exclusions of your policy.
2. Your insurance will make payments for any authorized and/or covered services. You are required to pay for services and materials that your insurance does not cover.
3. If your insurance requires a referral from another provider, we will require information of the referral to process your insurance with in-network benefits. Until this information is provided to us, we require you to pay all co-pays, deductibles and/or co-insurance relating to out-of-network benefits. Any over payments to your account will be reimbursed to you after insurance pays their portion.
4. If your insurance carrier has not paid your claim within sixty days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid your claim within ninety days of submission, you accept full responsibility for payment of any outstanding balance. If your account becomes delinquent and consequently gets forwarded to a collections agency, you accept full responsibility of all charges.
5. We require payment for any pre-set copays or non-insurance cases at the time of service. Deductible policies require you to pay $100 for the New Patient visit. You may pay the estimated deductible/co-insurance charges at time of service if you wish to avoid a statement in the mail.

I have read and understand and agree to abide by the information stated above as it applies to my coverage.

PARENT/GUARDIAN NAME (PRINT) _____ PARENT/GUARDIAN SIGNATURE _____ DATE _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic procedures, including a comprehensive exam, diagnostic testing, physical therapy techniques, massage or manual therapy, adjustments or manipulation, and acupuncture on me which are recommended by the doctors at Dakota Chiropractic & Wellness Center, and/or other licensed doctor of chiropractic who now or in the future render treatment to me while employed by or associated with Dakota Chiropractic & Wellness Center.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Although these are rare, they include but are not limited to, muscle sprain/strain, dislocations, fractures, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Although our patients are screened for indications that they are candidates for chiropractic manipulation to the best of our ability, I do not expect the doctor to be able to anticipate all risks and complications during the course of the procedure(s). Therefore, the doctor based upon the facts then known, will act in the best interest of the patient. I understand that I can terminate treatment at any time, even during the course of any of the chiropractic procedures listed above.

PARENT/GUARDIAN NAME (PRINT) _____ PARENT/GUARDIAN SIGNATURE _____ DATE _____