Shaft
Chiropractic

New Patient Kids Forms

Personal Information_____

First Name_____ Middle Initial_____ Last Name_____

Address_____

City_____ State_____ Zip Code_____

Home Phone (_____)_____ Cell Phone (_____)_____

Date Of Birth_____/_____/_____ Sex: ☐ Male ☐ Female

Social Security Number_____

Parent/Guardian Name_____ _____

Parent/Guardian Phone_____ _____

Parent/Guardian Email_____ _____

How did you hear about our office?_____

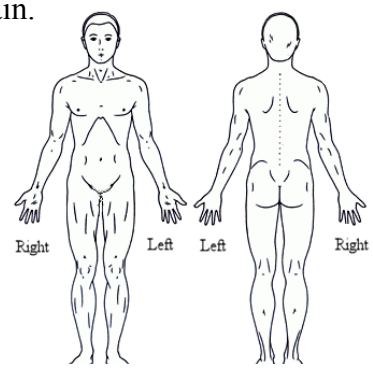
Symptoms:

Please check any current or past problems your child has on the list below:

☐ADD/ADHD	☐Dizziness	☐Kidney Infections / Stones	☐Stress
☐Anemia	☐Eating Disorders	☐Liver Disease	☐Stoke
☐Appendicitis	☐Emphysema	☐Lung Disease	☐Suicidal Tendencies
☐Arrhythmia	☐Epilepsy	☐Measles	☐Tension
☐Arthritis	☐Fatigue	☐Menstrual Cramps	☐Thyroid Disease
☐Asthma	☐Female Health Problems	☐Mental Disorder	☐Tuberculosis
☐Backaches	☐Fibromyalgia	☐Migraines	☐Tumors
☐Blood Clots	☐Gallbladder Disease	☐Miscarriage	☐Ulcers
☐Blurred Vision	☐Genital Herpes	☐Multiple Sclerosis	☐Urine Discoloration
☐Bowel Disorder	☐Glaucoma	☐Neck Pain	☐Vertigo
☐Broken Bones	☐Gluten Intolerance	☐Nervousness	☐Whooping Cough
☐Cancer	☐Gout	☐Night Sweats	
☐Carpal Tunnel	☐Headaches	☐Osteoporosis	Other:
☐Cataracts	☐Hearing Loss	☐Paralysis	
☐Chickenpox	☐Heart Disease	☐Pneumonia	
☐Cold Sores	☐Hemorrhoids	☐Polio	
☐Colitis	☐Hepatitis	☐Prostate Problems	
☐Constipation	☐High Blood Pressure	☐Reflux/ Ulcers	
☐Depression/Anxiety	☐High Cholesterol	☐Scoliosis	
☐Diabetes	☐HIV/AIDS	☐Seizures	
☐Digestive Disorders	☐Joint/Back Pain	☐Sexual Dysfunction	

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +



Health History:

Name of Pediatrician: _____ Date of last visit _____

Reason for visit: _____

Has your child ever taken antibiotics? Y/N Condition treated: _____

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N

If yes, describe (Sprain, Broken Bone, Head Trauma…) _____

Has your child ever been involved in a car accident? Y/N Date & Injuries _____

Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N _____

Prenatal History

Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted

Complications during pregnancy: Y/N List: _____

Ultrasounds during pregnancy: N Y Number: _____

Medications during pregnancy/delivery: Y/N List: _____

Cigarette / Alcohol use during pregnancy: Y/N

Birth intervention: O Forceps O Vacuum O Caesarian, Why?_____

Complications during delivery: Y/N List: _____

Birth weight_____ Birth length_____

Feeding history

Breast Fed: Y/N How long'?_____ Formula fed: Y/N How long'?_____

Type:_____ Introduced to solids at _____ months. Cow's milk at _____ months

Food / juice allergies or intolerances Y/N List: _____

Developmental History

Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____

At hat age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

Childhood Diseases

O Chicken Pox - Age ___

O Mumps - Age ___

O Rubella - Age ___

O Whooping cough - Age ___

O Measles - Age ___

O Meningitis - Age ___

O Tuberculosis - Age ___

O Other - Age _____

Shaft Chiropractic Wellness Financial Policy

We strive to provide the highest quality health care, all the while maintaining affordability for you, the patient. We understand that even with insurance, most patients will experience at least some out of pocket expense.

Participating Insurances
Our office will accept your insurance on assignment and do participate as preferred providers for many insurance plans. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your employer or insurance company. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery. We cannot be certain if your insurance covers chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is our policy and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays.

Non Participating Insurances
We will gladly bill your insurance company for you, and will call to determine your chiropractic benefits.. Payment is due at the time of service for all deductibles, co- pays, and non-covered therapies unless arrangements are with the office staff.

Patients without Insurance
We request that 100% of the examination and x-ray exam be paid at the time of the visit, unless other arrangements have been made. To qualify for our Time of Service Reduction in fees you must pay on the day the service was performed. We are happy to accept cash, check, Master Card, Visa, Discover or American Express. No insurance will be billed.

Medicare
Our office accepts assignment from Medicare. Reimbursement is sent directly to our office in payment for chiropractic services that Medicare will cover. Medicare will ONLY cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

I have read and understand this financial policy. I realize that I am responsible for all charges incurred by me at Shaft Chiropractic Wellness. I agree to the above terms and authorize Shaft Chiropractic Wellness to collect from me if payment it is not received within ninety (90) days after the time of service.

Signature of Patient/Parent/Legal Guardian
_____

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Signature of Patient/Parent/Legal Guardian
_____

Content to Treat a Minor

I hereby authorize and give consent for Shaft Chiropractic Wellness to examine, and if needed, treat my minor child; (child name(printed)_____.

Signature of Patient/Parent/Legal Guardian
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