PEDIATRIC PATIENT INTRODUCTION

Child's Name:_____ Mother's Name:_____ DOB:_____

Case Number:_____ Father's Name:_____ DOB:_____

Address:_____ City/Town:_____ State:_____ Zip:_____

Home Phone:_____ Mother's Work Phone:_____ Mother's Cell Phone:_____

Email:_____ Father's Work Phone:_____ Father's Cell Phone:_____

Birth Date:_____ _____ _____ Age:_____ Sex:_____ Number of Siblings:_____ Referred by:_____

Birth Weight:_____ Birth Length:_____ Current Weight:_____ Current Length:_____

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Suction Cap or Vacuum_____

Location: Home_____ Birthing Center_____ Hospital_____

Problems During Pregnancy:_____

Problems During Labor/Delivery:_____

Apgar Scores:_____ _____ Was there presence at birth of: Jaundice (Yellow)? _____ Cyanosis (Blue)? _____

Congenital Anomalies/Defects?_____ If Yes, Please Explain?_____

Infant Feeding: Breast_____ Bottle_____ If Bottle, Which Formula? _____

Number of Hours Sleeping per Night:_____ Quality of Sleep: Good_____ Fair_____ Poor _____

Obstetrician/Midwife:_____

Pediatrician/Family MD:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Immunization History:_____

Number of doses of antibiotics your child has taken: During the past six months_____ During his/her lifetime_____

Previous Chiropractor:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Has your child ever been treated on an emergency basis?_____ If yes, please explain:_____

Purpose of this Appointment:_____

Insurance/Billing Information:_____ Policy #:_____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

SIGNED:_____ WITNESSED:_____ DATE_____ _____ _____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

SIGNED:_____ DATE_____ _____ _____

PEDIATRIC CASE HISTORY

Delivery/Birth History:_____

_____

_____

_____

At what age did the child:

Respond to Sound_____ Follow an Object with His/Her Eyes_____ Hold Head Up _____

Sit Alone_____ Crawl_____ Stand_____ Walk Alone_____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____

Rubeola_____ Whooping Cough_____ Other_____

Has this child ever suffered from:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to_____
☐ Sinus Trouble	☐ Poor Posture	☐ Diabetes	☐ Allergies to_____
☐ Asthma	☐ Scoliosis	☐ Hypertension	☐ Allergies to_____
☐ Colds/Flu	☐ Walking Trouble	☐ Anemia	☐ Other_____
☐ Colic	☐ Broken Bones	☐ Bed Wetting	☐ Other_____

Has this child ever suffered the following spinal traumas?

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from highchair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other_____

Has this child ever sustained an injury playing organized sports?_____ If yes, please explain:_____

_____

Has this child ever sustained injuries in an auto accident?_____ If yes, please explain:_____

_____

Present History:_____

_____

_____

_____

Surgery:_____

Medications:_____

Accidents:_____

Family History:_____

Boesky Chiropractic, PLC Informed Consent for Chiropractic Care

We encourage and support a shared decision making process between us regarding your health needs. As part of that process you have the right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

• Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

• Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal of chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays).

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.
In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. ANDREW BOESKY TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ Date _____
Patient Signature

_____ Date _____
Boesky Chiropractic, PLC Signature

Parental Consent for Minor Patient:

I do hereby request and authorize the doctor to perform necessary services for the child named above, deemed advisable by the doctor. I certify that there are no court orders now in effect that prohibit me from signing this consent.

Patient Name:_____ Patient Age: _____ DOB: _____

Parent/Guardian Name _____Relationship to the minor _____

Parent/Guardian Signature: _____

Boesky Chiropractic, PLC Signature _____

☐ I request that my child be able to maintain their chiropractic appointments without the presence of a parent/guardian when necessary. (This applies to children 14 years of age or older.)

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature Boesky Chiropractic, PLC Date

Insurance and Financial Agreement

If we can verify that you have coverage for care at this office, we will be glad to bill your insurance company for you. If your insurance company does not pay, or does not pay the full amount that we billed, you will be responsible to pay the balance upon receipt of insurance denial. *Please note verification of coverage does not guarantee payment by your insurance company. If there is a difference in the verified amount and the actual amount paid you will be responsible.

If you need to make special arrangements for payment, please let us know before you see the doctor today. Thank you!

First Health Insurance Company _____

Policy Number _____ Employer or Group # _____
If not your own name, whose name is the policy under? _____
What is this person's relationship to you? ____Spouse ____Parent
What is this person's date of birth? ____/____/_____

Second Health Insurance Company _____

Policy Number _____ Employer or Group # _____
If not your own name, whose name is the policy under? _____
What is this person's relationship to you? ____Spouse ____Parent
What is this person's date of birth? ____/____/_____

Please check one below:

☐ "I will pay cash for my care."
"I understand that payment is due at time of service unless other written arrangements are made in advance".

☐ "Bill my insurance for my care and I agree to pay what they reject"
"I understand that my insurance coverage is a contract between me and my insurance company. If my insurance does not pay, or does not pay in full, I agree to pay the balance due at the time of insurance denial."

Print your name here _____

Sign here _____ Date _____

Witnessed by Boesky Chiropractic _____

A note about your records at this office:
According to Michigan law, your health records, including all x-rays are the permanent property of our office. You are entitled to the information contained within your records but we cannot release your records directly to you. Copies of your x-rays can be made by us at a facility that performs this service, and given to you for a fee. If another physician requests your x-rays in writing from our office we will send them to that physician and they will be returned to us by that office. Thank you

HIPAA Consent for Purposes of Treatment, Payment & Healthcare Operations

I acknowledge that **Boesky Chiropractic, PLC** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **Boesky Chiropractic, PLC** Notice of Privacy Practices prior to signing this document. **Boesky Chiropractic, PLC'** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Boesky Chiropractic, PLC**. The Notice of Privacy Practices for **Boesky Chiropractic, PLC** is also provided on request at the main administration desk of this practice and on **Boesky Chiropractic, PLC"** website at www.chiroandy.com. This Notice of Privacy Practices also describes my rights and **Boesky Chiropractic, PLC'** duties with respect to my protected health information.

Boesky Chiropractic, PLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing **Boesky Chiropractic, PLC** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Relationship to Patient (Self, Parent, Guardian, etc)