101 Drake Lane, Milford, PA 18337
Phone: (570) 409-9500
Fax: (570) 409-9505

Patient Information

(Children 10 & under)

Child's Full Name _____ Date:_____

Parent/Guardian Name(s) _____

Email* _____ * Your email will NOT be shared with any 3d parties and is used for occasional office announcements and promotions.

Address: _____ City:_____ State: _____ Zip: _____

Phone *Home* (_____)_____ *Cell* (_____)_____ Carrier _____

Please provide carrier for reminder text messages

Primary Contact ☐ Cell ☐ Home Reminder Text Message ☐ Yes ☐ No

Birth Date: _____ Age: _____ Social Security Number: _____-_____-_____ ☐ Female ☐ Male

Emergency Contact: _____ Emergency Phone Number: (_____)_____

Whom may we thank for referring you? _____

Health Questionnaire

Current Complaints

Reason for visit today?: _____

When did symptoms start? _____How often are symptoms experienced? (Circle one) Constantly Frequently Occasionally

Describe symptoms? (Circle all that apply): Sharp/ Dull/ Stiff/ Tight/ Aching/ Spasms/ Throbbing / Stabbing/ Shooting/ Burning/ Cramping/ Tingling/Numbness/ Other_____

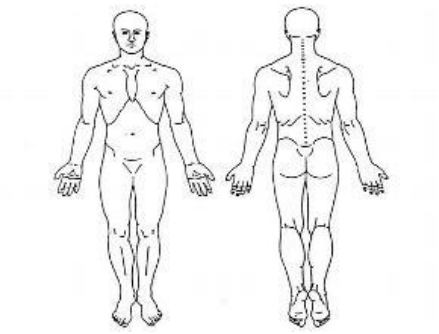
Rate pain based on face below:

What makes it better? _____

What makes it worse? _____

Does the condition interfere with any of the following (Circle all that apply): Sleep/ Getting in or out of bed or chair/ Personal care/ Travel/ Work/ Recreation/ Lifting/ Walking/ Standing/ Daily Routine/ Social Activities/ Exercise/ Other:_____

Describe location of problem and draw on diagram.



Have you (child) seen a chiropractor before? ☐ Yes ☐ No How long ago? _____

Medical History

Height: _____ Weight: _____

Please list any current medications and/or supplements: _____

Please list/describe any serious injuries or diagnoses (broken bones, seizure disorder, etc): _____

Family History (list all major diseases such as cancer, heart problems, bone diseases and the relation to the child):

Habits:

Caffeine (soft drinks)	○	Light	○	Moderate	○	Heavy	○ None
Exercise	○	Light	○	Moderate	○	Heavy	○ None
Sleep	○	Light	○	Moderate	○	Heavy	○ None
Water	○	Light	○	Moderate	○	Heavy	○ None
Salty Foods	○	Light	○	Moderate	○	Heavy	○ None
Sugary Foods	○	Light	○	Moderate	○	Heavy	○ None
Artificial Sweeteners	○	Light	○	Moderate	○	Heavy	○ None
Stress	○	Light	○	Moderate	○	Heavy	○ None

Additional comments you would like the doctor to know: _____

Financial Policy

Insurance Coverage

Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. We will accept your insurance in any of the plans that we are providers with. Certain insurance companies will only allow a particular number of visits per year and/or per diagnosis code. If your insurance company denies your care in total and/or partial with regards to the amount of visits necessary for the treatment of your condition, you will be responsible for the remainder of the balance.

It is our office policy to collect either a co-pay/co-insurance or an estimated insurance deductible <u>at the time of visit</u>.

It is our policy that all appointments must be canceled <u>24 hours prior to scheduled time other than for weather related cancellations.</u> Anyone canceling appointments with less notice, regrettably, <u>will be charged</u> a $45.00 fee for the appointment. If we are not in the office a message on our answering machine will do. THIS IS A POLICY WE DO ENFORCE.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ _____/_____/_____

Signature of parent/guardian Date

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me by the Doctor of Chiropractic of Advanced Chiropractic and/or any other Doctor of Chiropractic, who now or in the future treats me while employed by, working or associated with, or serving as back-up for the Doctors of Chiropractic named below, including those working at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fracture, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent for to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Chiropractic Consent to evaluate and adjust a minor child:

I, _____ (Parent/guardian name) being the parent or legal guardian of _____ (child's name) have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Printed Name of parent/guardian Date

_____ _____

Signature of parent/guardian Witness