PEDIATRIC PATIENT INTRODUCTION

Child's Name:_____ Mother's Name:_____
Father's Name:_____
Address:_____ City/Town:_____ State:_____ Zip:_____

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

Birth Date:__ __ __ Age:____ Birth Weight:_____ Current Weight:_____
Sex:____ No. of Siblings:_____ Birth Length:_____ Current Length:_____

Type of Birth: Normal Vaginal ____ Forceps ____ Breech ____ Cesarean ____
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:_____

Infant Feeding: Breast_____ Bottle_____ Formula_____
No. of Hours Sleep per Night:_____ Quality of Sleep: Good____ Fair____ Poor____

Obstetrician/Midwife:_____

Pediatrician/Family MD:_____

Date of Last Visit to MD:_____

Immunization History:_____

Purpose of this Appointment:_____

Has Your Child Been Treated on an Emergency Basis?:_____

Describe:_____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this clinic and it's Doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed:_____ Witnessed:_____ Date: __ __ __

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. X-Rays remain the property of this clinic.

Date: __ __ __ Signature:_____

PEDIATRIC CASE HISTORY

Pregnancy History:_____

Delivery/Birth History:_____

Developmental 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

Childhood Diseases:
_____ Chicken Pox
_____ Mumps
_____ Measles
_____ Rubella
_____ Rubeola
_____ Whooping Cough

Other:_____

Has Child Ever Suffered From:

__ Dizziness
__ Diabetes
__ Arthritis
__ Neuritis
__ Anemia
__ Poor Appetite
__ Bed Wetting
__ Fainting
__ Neck Problems
__ Joint Problems
__ Backache
__ Tuberculosis
__ Headaches
__ Digestive Disorders
__ Rheumatic Fever
__ Hyperacitivity
__ Convulsions
__ Walking Prblms
__ Arm Problems
__ Heart Troubles
__ Hypertension
__ Asthma
__ Sinus Trouble
__ Orthopedic Prblm
__ Sugar Concentrat
__ Paralysis
__ Broken Bones
__ Leg Problems
__ Chronic Earaches
__ Colds/Flu
__ Allergies
__ Constipation
__ Diarrhea
__ Behavioral Prblm
__ Muscle Jerking
__ Ruptures/Hernias
__ "Growing Pains"

Present History:_____

Surgery:_____

Medications:_____

Accidents:_____

Family History:_____

PATIENTS CONDITION

Name_____ Date_____

Reason for visit_____

Rate the severity of your pain on a scale of 0 (no pain) to 10 (severe pain) _____

Describe the onset of discomfort ( ) Gradual ( ) Sudden

When did the discomfort/symptoms begin? _____

Since the problem began are the symptoms ( ) Worse ( ) Better ( ) Same

What aggravates the discomfort? ( ) Bending ( ) Carrying ( ) Lifting ( ) Lying Down

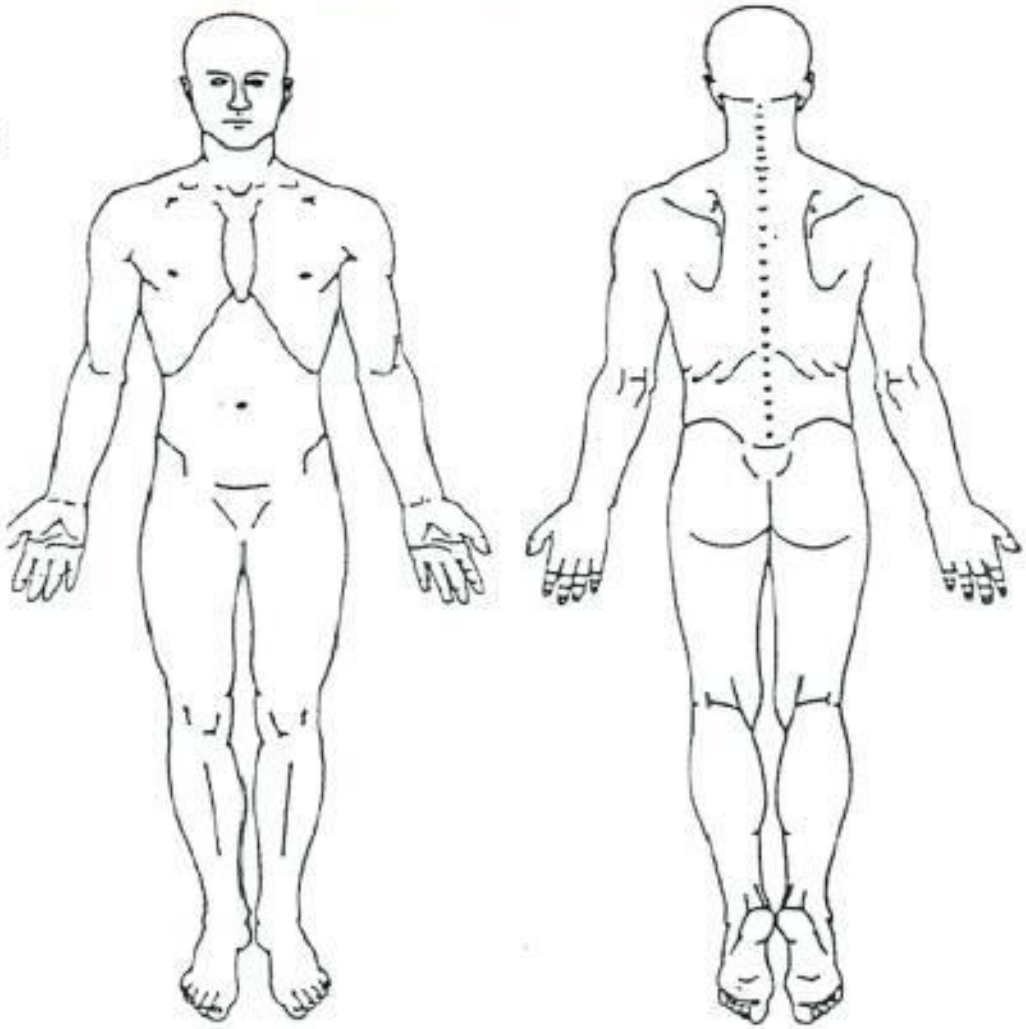
( ) Sitting ( ) Standing ( ) Twisting ( ) Walking

Type of pain: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness ( ) Aching ( ) Shooting

( ) Burning ( ) Tingling ( ) Cramps ( ) Stiffness ( ) Swelling ( ) Other

On the diagram below, using the key, please indicate where you are currently experiencing pain or other symptoms.

A- ACHE
B- BURNING
N- NUMNBESS
P- PINS & NEEDLES
S- STABBING
O- OTHER



KNOPP CHIROPRACTIC

Authorization for Medical Treatment of Minor Child

Patient Name: _____

I hereby request and authorize Knopp Chiropractic to perform diagnostic tests and to render chiropractic adjustments and other treatments to _____, a minor child. This authorization also extends to all doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

By signing below, I hereby certify that as of the date hereof, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent, or guardian is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DATE: _____ _____
SIGNATURE

_____ _____
WITNESS PRINTED NAME

_____
RELATIONSHIP TO PATIENT

****

RESPONSIBLE PARTY INFORMATION

Parent or Guardian responsible for billing: _____

Billing Address: _____

_____

Billing phone #: _____

Child's Address if different from responsible party's address:

_____

_____

CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFO

Any release of records or x-rays will be done with separate signed authorization form.

Through the use of this consent form, Knopp Chiropractic is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or health care operations, is available for you to read and you are hereby encouraged to do so prior to signing this consent.

2. This office reserves the right to change its privacy practices that are described in the privacy practices notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.

3. You have a right to request that this office restrict how protected health information is used and/or disclosed to carryout treatment, payment and/or healthcare operations. This office is not required to agree to any restrictions that you have requested.

4. I understand and consent to the following appointment reminders that will be used by Knopp Chiropractic: a.) a postcard mailed to me at the address provided by me; and b.) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

5. You have the right to revoke this consent, in writing to the Privacy Officer at this office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice. I understand that if I am giving this authorization as a condition of obtaining insurance coverage and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

6. I understand that if I revoke this consent at any time, Knopp Chiropractic has the right to refuse treatment

7. I understand this consent is valid for seven years.

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I _____ acknowledge that I have received the Notice of Privacy Practices and was given an opportunity to have all my questions answered.

Signature:_____ Date:_____

Legal Representative:_____ Relationship_____ Date:_____

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form.

Signature:_____ Date:_____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____ _____
Print Name Relationship

_____
Signature

Cancellation Policy

If you need to cancel your appointment, please call us at 743-2866. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible. You may also respond to your appointment reminder text and or email you receive prior to your appointment.

Beginning January 1, 2020 there will be a $25 fee assessed for all no show appointments.

When you book an appointment, you are holding a space on our schedule that is no longer available to our other patients. In order to be respectful of your fellow patients, please call the office as soon as you know you will not be able to make your appointment.

Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

We appreciate your cooperation in this matter.

Patient
Signature:_____ Date:_____