Broom Chiropractic

NEW PATIENT CHILD

ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	
GENDER:	WEIGHT:

ABOUT THE PARENT

PARENT NAME:	
ADDRESS: ❑ SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S SOCIAL SECURITY NUMBER:	
INSURED'S DATE OF BIRTH:	

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY ❑ OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: ❑ GOTTEN WORSE ❑ STAYED CONSTANT❑COME AND GONE
DOES THIS CONDITION INTERFERE WITH: ❑ SLEEP ❑DAILY ROUTINE ❑ OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? ❑YES ❑NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ❑YES ❑ NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

CHILD'S CURRENT HEALTH STATUS

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? ❑ YES ❑ NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❑YES ❑ NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER HAD A SEVERE FALL? ❑ YES ❑ NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ❑ YES ❑ NO PLEASE EXPLAIN:
IS YOUR CHILD ACCIDENT PRONE? ❑ YES ❑ NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER HAD SURGERY? ❑YES ❑ NO PLEASE EXPLAIN:
IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? ❑YES ❑ NO PLEASE EXPLAIN:

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now or had had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

❑ ALLERGIES	❑ CONSTIPATION	❑IRRITABILITY
❑ ASTHMA	❑ DIGESTIVE PROBLEMS	❑ SKIN PROBLEMS
❑ ATTENTION PROBLEMS	❑ EAR PROBLEMS	❑ SLEEPING DISORDERS
❑ BED WETTING	❑ FREQUENT COLDS	❑ TUBES IN THE EARS
❑ BREATHING PROBLEMS	❑ HEADACHES	❑ VISION PROBLEMS
❑ COLIC	❑ HYPERACTIVITY	❑ OTHER:

INFORMATION ABOUT POSSIBLE RISK OF CHIROPRACTIC TREATMENT

You have the right, as a patient, to be informed about your condition and the recommended procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you; it is simply an effort to make you better informed so you may give or withhold you consent to the procedure. Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of a treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disc injuries or physiotherapy burns. These are extremely rare occurrences.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctor in this chiropractic to administer chiropractic care, to use adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

I authorize the use of this signature to allow the insurance companies to pay McBroom Chiropractic directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view changes to your records. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly. Obtain payment from third party payers. Conduct normal healthcare operations such as quality assessments and physician's certifications. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE: