R S R B R R I

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State ____ Zip
Home Phone _____
Cell Phone _____
Email _____
Sex ❑ M ❑ F Age ____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

_____

If your child is already experiencing a symptom, please describe it:

_____

_____

_____

_____

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

_____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ DFN2W ❑ VWDWLRQDO DEHWHV ❑ Pre/ clampsia ❑ 6WUHS ❑ Nauseau/ omitting

❑ H7HUP)DWLJH ❑ 6OOLQJ ❑ 2WUSOHDVHGHVFULEH _____

_____

BIRTH HISTORY

❑ VSLWDO ❑ UWHQWHU ❑ PH ❑ 1RUPDO9DJLQDO ❑ Breech

❑ VDUHDQ ❑ 6FHGHG,QGHG ❑ (SLGXUDO

REOHPVGLQJODERUGHOLYHU _____

_____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium

❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Rubeola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies
❑ Anemia
❑ Arm Problems
❑ Asthma
❑ Back Aches
❑ Bed Wetting
❑ Behavioral Problems
❑ Broken Bones
❑ Chronic Ear Aches
❑ Colds/Flu
❑ Colic
❑ Convulsions/Seizures
❑ Delayed Speech
❑ Diabetes
❑ Digestive Issues (constipation/diarrhea)
❑ Dizziness
❑ Fainting
❑ Headaches
❑ Heart Trouble
❑ Hyperactivity
❑ Hypertension
❑ Jeuvenile Rheumatroid Arthritis
❑ Joint Problems
❑ Leg Problems
❑ Neck Problems
❑ Neuritis
❑ Orthopedic Problems
❑ Paralysis
❑ Poor Appetite
❑ Ruptures/Hernias
❑ Sinus Trouble
❑ Tuberculosis Walking
❑ Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have? _____

Children's' Ages: _____

Childrens' health concerns: _____

_____

Number of pregnancies: _____

Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Health concerns regarding this pregnancy? _____

_____

Authorization for Care of Minor

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

Signed: _____ Witnessed: _____ Date: _____

INSURANCE INFORMATION (IF APPLICABLE)

Name of insured _____
Date of Birth _____
Insurance Company _____
Phone # _____
ID # _____
Policy# _____

FINANCIAL INFORMATION

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. As a courtesy, Lighthouse Chiropractic will verify my insurance. I understand that "VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF COVERAGE OR PAYMENT. IT WILL BE BASED ON MEDICAL NECESSITY, CONTRACT EXCLUSION AND ELIGIBILITY AT THE TIME OF SERVICE." Furthermore, I understand that Lighthouse Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to Lighthouse Chiropractic will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend or terminate my case and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Name | Patient Signature | Date

Guardian's Name | Guardian's Signature | Date

CREDIT CARD POLICY

Please note that when you use a credit card in our office, it is **automatically saved** and will be used to pay for future appointments. **If you do not want to keep your card on file, please pay with cash or check.**

CONSENT TO INITIATE CARE

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Our only practice objective is to eliminate subluxation which interferes with the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations

I, _____, have read and fully understand the above statements.
(Please Print Name)

I hereby authorize the Doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient above, and further authorize the consent that the Doctor chooses and employs such assistance as he sees fit. I also understand that prior to care, a full explanation of the procedure(s) involved will be given.

Patient/Guardian Name | Patient/Guardian Signature | Date

Notice of Privacy Practices Acknowledgement
Lighthouse Chiropractic

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

OR

_____

Signature of Personal Rep Date

Authority of Personal Representative to Sign for Patient (check one):

___ Parent ___ Guardian ___ Power of Attorney _____ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

_____

Lighthouse Chiropractic Office Use Only

I tried to obtain written Acknowledgement by individual note above of recipt of our **Notice of Privacy Practices**, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgment

___ A communication barrier prevented us from obtaining acknowledgement

___ The individual was unwilling to sign

___ Other: _____

_____ _____

Signature of Personal Representative Date

Medical Information Release Form

(HIPPA Release Form)

_____ _____

Patient's Name (Please Print) Patient's Date of Birth

Release of Information

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____ My Insurance Company (only minimum necessary information needed for billing purposes)

_____ Spouse _____
(Name – please print)

_____ Child(re _____
(Name(s) – please print)

_____ Other _____
(Name/relationship – please print)

_____ My information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

_____ _____

Signature of Personal Representative Date