Pediatric Patient Questionnaire

**Please fill out as thoroughly as possible as this will help us to serve you optimally!

CONFIDENTIAL PATIENT INFORMATION

Childs Name: (First) (Last) (MI)

Parent/Guardian Name(s):

Child SS#: - - DOB: / / Age: Sex: M F

Marital Status: # of children (if any) Occupation:

Street Address: Height ft in

City: State: Zip Weight lbs

Email: Cell phone: - - Other phone: - -

Emergency contact Emergency relation: Emergency phone: - -

How did you hear about us?
(if you were referred by someone please let us know)

Who is your child's primary care physician?:

Date and reason for last doctor visit:

Is your child receiving care from any other health professionals? ☐ Yes ☐ No
If Yes please name them and their specialty:

Race: Ethnicity: ☐ choose not to specify

Preferred language: ☐ English ☐ Spanish ☐ Sign lang ☐ other

Verification question: Mothers maiden name (first) (last)

Please note any significant <u>family medical history</u>:

Please list any drugs/medications/vitamins/herbs/other that your child is taking

HEALTH GOALS FOR YOUR CHILD:

What are your top three health goals for your child?:

1._____
2._____
3._____

What would you like to gain from chiropractic care?

☐ resolve existing condition
☐ overall wellness
☐ both

Have you ever visited a chiropractor? Yes No If yes, what is their name?

What is their specialty? Pain relief physical therapy & rehab nutritional subluxation based other

CURRENT HEALTH CONDITIONS

What health condition (s) bring your child to be evaluated by a chiropractor?

Has your child received care for this condition before? Yes No

- If yes please explain:

When did the condition(s) first begin?

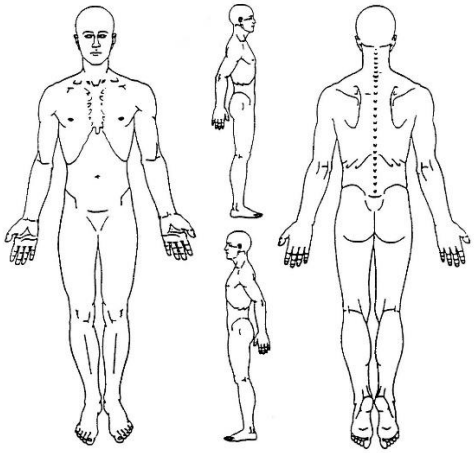
How did the problem start? Suddenly gradually post injury

Is this condition getting worse improving intermittent constant unsure other:

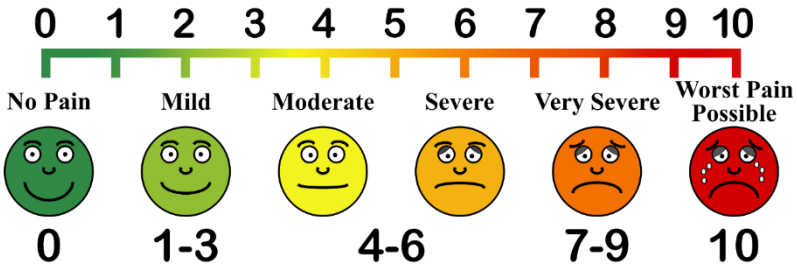
What makes the problem better?:

What makes the problem worse?:

Place an " X " on the drawings to the left wherever you have pain. Mark an "O" for past conditions or issues.



If applicable please rate your pain level(s). Indicate for what region if affected.



DOCTORS NOTES: (PLEASE LEAVE BLANK)

BP: /

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy with the child who is being seen today

Any fertility issues? Yes No If Yes, please explain:

Did mother smoke? Yes No If Yes, how many per week:

Did mother drink ? Yes No If Yes, how many per week:

Did mother exercise? Yes No If Yes, please explain:

Was mother ill? Yes No If Yes, please explain:

Any ultrasounds? Yes No If Yes, please explain:

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any notable concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

Child's birth was: ☐ Natural vaginal birth ☐ scheduled c section ☐ emergency c section At how many weeks was your child born?

Child's birth was: ☐ at home ☐ at birthing center ☐ at a hospital ☐ other: Doctor/OB's Name:

Please check any applicable interventions or complications:
☐ Breech ☐ Induction ☐ Pain meds ☐ Epidural ☐ episiotomy ☐ vacuum extraction ☐ forceps ☐ other:

Please describe any other concerns or notable remarks about your child's labor and/or delivery :

Childs birth weight:____lbs _____oz Childs birth height: _____ in APGAR score at birth: APGAR after 5 min:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? Yes No If yes how long? Difficulty breastfeeding? Yes No

Did they ever use formula? Yes no If yes at what age? If yes what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? Yes no
If yes please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? Yes no

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____
Teethe:_____ Sit alone: _____ Crawl _____ Walk _____ Begin cows milk _____ Begin solid foods _____

Please list an food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ☐ No ☐ yes, on a delayed or selective schedule ☐ yes, on schedule
If yes, please list any vaccination reactions:

Has your child received any antibiotics? Yes No If yes, how many times and list reason: Night terrors or difficulty sleeping? Yes No If yes, please explain:
Behavioral, social, or emotional issues Yes No If yes, please explain:
How many hours per day does your child typically spend watching a TV, computer, tablet or phone?
How would you describe your child's diet? ☐ Mostly whole, organic foods ☐ pretty average ☐ high amount of processed foods

*** I certify that the information provided is accurate to the best of my knowledge:**

Today's Date: ____/____/____ Printed name of patient: _____

Signature of Patient/legal guardian:_____

Creekwood Chiropractic West Point | www.creekwoodchirowestpoint.com
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Creating a Healthier World, One Family at a Time

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Financial Agreement

Let's clarify the financial aspects of your care so that we can direct all of our attention to balancing your body!

Outlined below is our financial agreement

Please let us know if you would like a copy of this agreement for your own reference

Insurance:
Insurance is a contract between you and your insurance company.

- You will need to pay your co insurance and or co- payments at the time of service.
- Failure to provide complete insurance information may result in patient responsibility for the entire bill.
- It is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by them.
- Dependent on your insurance company, some additional therapies (need determined by your DC) may **not** be covered such as **hydrotherapy, decompression therapy, traction therapy, ultrasound, electric stem, etc**. Final determination is based upon your insurance carrier.
- It is the responsibility of the patient to verify with your insurance company if the provider(s) you are seeing are contracted with the insurance. **If your insurance company requires a referral and/or preauthorization, it is your responsibility to obtain and provide it to our office.** Failure to obtain the referral and/or pre authorization may result in denial from the insurance company, and the balance will be your responsibility.
- I am responsible for updating my health insurance information with the office any time the information changes, terminates, or new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
- If you were injured on the job, in an auto accident or some other personal injury you may have other options.

Medicare: We are a participating provider with Medicare Part B. We agree to bill and accept contractual adjustments from Medicare. There may be services and supplies rendered in our office that are NOT covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) be signed by the patient/Guarantor. By signing the ABN, it is understood that you are financially responsible for payment of any services and/or supplies that are not deemed medically necessary by Medicare.

No Insurance Coverage: Payment is typically expected on the day that services are rendered. A fee reduction is applied to services **only** if paid in full at the time of service. Any "billed" services are subjected to a **$5** fee per service date. We accept cash, check or credit card. **Family Cash Plans** are also available.

Individual Consideration: If there is financial hardship associated with care in our office, please understand that we have never refused any client due to their financial situation. We will however come to some agreement for payment of services that both parties can agree on. This is set up on an individual basis.

Monthly Statements: If there is a personal patient balance on the account, we will send you a monthly statements. Patients are responsible for all charges resulting from treatment provided at Creekwood Chiropractic West Point. Payment is due within 30 days of receipt of this statement, unless other financial agreements have been made.

Questions on statements can be directed to **Karrie** at 402.371.0522

Past Due Accounts: I understand and agree that if my account is delinquent past 90 days without financial agreement, I may be turned over to the collection agency used by Creekwood Chiropractic and visits thereafter will need to be paid on a per visit basis or under an auto monthly agreement at the time of service without exception.

Upsets: We are here to serve you and your family. Please speak with one of the Doctors about anything that is upsetting you about our policies or service. We see your comments as helping us to help you as well as others and improve on your overall experience.

Referrals: We ask that you consider us for referrals for your friends and family! It is important to us to deliver the message of true health to the community and we ask for YOUR help in doing so. Your referrals are our greatest compliment and we thank you!

Agreement:

This is the entirety of the financial agreement between Creekwood Chiropractic West Point and the patient below. I have read this agreement, understand it and agree with its provisions.

_____
Patient's Name Printed

_____
Patient Signature

_____
Guardian Signature (if applicable)

Date: ____/____/ _____

Like and follow us on Facebook to stay up to date on events as well as health and wellness information!

Receive special discounts on products when you take the time to rate us on Facebook and let others know what chiropractic has done for YOU!

INSURANCE INFORMATION

(if you are not utilizing insurance please leave this page blank)_

Please check any and all insurance coverage that may be applicable in this case:

___ Major Medical ___ Worker's Compensation ___ Medicaid ___ Medicare ___ Auto Accident
___ Medical Savings Account & Flex Plans ___ Personal Injury ___ Other

***Please indicate which is **Primary** and **Secondary** if applicable*

INSURANCE AUTHORIZATION AND RELEASE

*****Please carefully read the following and sign below*****

**I certify that I have read and understand the provided insurance information to the best of my knowledge and the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.*
**I authorize the physician to release any information including my diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners.*
**I authorize and request my insurance company to pay directly to the physician's office, insurance benefits that are otherwise payable to me.*
**I understand that my insurance carrier may pay less than the actual bill for services.*
**I understand that I am responsible for all copays, deductibles, co-insurance and balances.*

X _____
Signature of patient (or parent if minor)

PLEASE READ AND SIGN
(FOR EVERYONE)

** We invite you to discuss with us any questions regarding our services. The best services are based on a friendly mutual understanding between provider and patient*

** Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.*

**I understand that I am responsible for all copays, deductibles, co-insurance and balances.*

**I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.*

**As with any form of healthcare, some risks are present, and although non- intentional by the provider, I am aware of these risks. I acknowledge that I can ask the provider any and all questions I may have regarding my healthcare.*

**I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I provided.*

X _____ Date: ___/ ___/ ___
Signature of patient (or parent if minor) Relationship to patient: (circle one) Self Parent /Guardian Spouse

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Patient Name: X _____ Patient # _____
(Last) (First) (Middle)

_____ I have received the _____Notice of Privacy Practices.

X _____ _____/_____/_____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Relationship to Patient Privacy Notice Version #

_____ _____
Witness Location Privacy Notice Written Acknowledgement was obtained (if more than one clinic location)

Documentation of Good Faith Effort

- ☐ Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient, parent, legal guardian declines to acknowledge the receipt of the Notice of Privacy Practices.
- ☐ Patient/parent/legal guardian states they has already received the Privacy Notice
- ☐ Patient/Parent/legal Guardian directed our clinics website to view the Notice of Privacy Practices
- ☐ The Notice of Privacy Practices was mailed to the patient/patent/legal guardian
- ☐ Other _____

_____ _____ _____/_____/_____
Witness Date: