Maximized Health
CHIROPRACTIC

NEW PATIENT FORMS – CHILD
Please print clearly

GENERAL INFORMATION (please complete in detail, all information is confidential)

Child's Last Name: _____ First Name: _____ MI: ___

Parent/Guardian Last Name: _____ First Name: _____ MI: ___

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ Email: _____

Phone (Work): _____ Phone (Cell): _____

Number of Children:

Spouse Name: _____

Phone: _____

Employer: _____

Today's Date / /	Age	Date of Birth / /	Sex: M F	Social Security Number - -	☐Married ☐Single ☐Divorced ☐Widowed

In Care of: _____ Relation: _____Phone: _____
(Parent or financially responsible person)

Patient Employer's Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Occupation: _____

Referred By:

Driver's Lic. #:

EMPLOYED
☐ Full Time ☐ Part Time
☐ Retired ☐ Not Employed

STUDENT
☐ Full Time ☐ Part Time

INSURANCE INFORMATION

COMMERCIAL INSURANCE ONLY

Primary Insurance Company Name

_____

Type: _____ Group: _____ Private: _____

Membership/Cert #: _____

Policy / Group #: _____

Complete ONLY if patient is not the insured
Insured's Name: _____

M F ☐ Married ☐Single ☐Widowed ☐Divorced

Patient's Relationship to Insured: _____

Insured's Date of Birth: _____

Insured's Employer: _____

Secondary Insurance Company Name

_____

Type: _____ Group: _____ Private: _____

Membership/Cert #: _____

Policy / Group #: _____

Complete ONLY if patient is not the insured
Insured's Name: _____

M F ☐ Married ☐Single ☐Widowed ☐Divorced

Patient's Relationship to Insured: _____

Insured's Date of Birth: _____

Insured's Employer: _____

AUTOMOBILE ACCIDENT ONLY

Insurance Company: _____ Claim #: _____ Policy #: _____

Address: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____ Adjuster's Name: _____

Attorney's Name: _____ Contact Name: _____Phone: _____

Address: _____

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CHILDREN'S HEALTH & INJURY HISTORY INFORMATION

Child's Name: _____Age_____ Parent's Name_____

1 Please check health complaints your child is currently experiencing or has experienced in the last six months.

□ Asthma □ Headache □ Ear infection □ Colic □ Allergies □ Bed wetting
□ Ear Infections □ ADHD □ Chronic Colds □ Digestive Problems □ Asthma / Allergies
□ Scoliosis □ Seizures □ Car Accident □ Neck Pain □ Back Pain □ Other Pain

Additional parent comments about child's health status _____
_____
_____

2 When was the last time your child had a spinal examination to determine proper alignment for optimal growth and development, and by whom?_____

3 Pregnancy normal? □ Yes □ No Explain: _____
Birth complications? □ Yes □ No Explain: _____
Delivery: □ Home □ Hospital Complications: _____

4 How many prescriptions of antibiotics has your child taken:
During the past six months_____, Total during his/her lifetime_____

5 How many other prescription medications has your child taken:
During the past six months_____, Total during his/her lifetime_____
What kind?_____

6 According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc) during their first year of life. Has this happened to your child? □ Yes □ No If yes, please explain _____
_____

7 Please circle which contact sports your child participates in:
Soccer / Football / Gymnastics / Karate / Hockey / Basketball / Dance / other_____
_____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT FORM

This form will help us coordinate the exchange of information and release of 3rd party reimbursement.

Assignment of Insurance Benefits and Payment Guarantee

I, _____ assign to Maximized Health Chiropractic (MHC)
(Print name)
any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patient for services rendered by MHC. Patient also assigns to MHC any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by MHC. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare cost to make all payments for healthcare services rendered by MHC directly to MHC.

Release of Information

Patient herby authorizes MHC to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all test of any type or character of patients such persons as MHC deems appropriate.

I, _____ understand and agree that health and accident
(Print name)
insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Maximized Health Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Maximized Health Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

_____

Parent/Guardian Signature Date

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

It is important that each patient understand both the objectives and the methods of chiropractic care. This will certainly prevent any confusion or problems in the future.

Adjustment: An adjustment is the specific application of forces and physiotherapy techniques to facilitate the reduction or correction of spinal misalignment, aka subluxation.

Health: A state of optimal function and not merely the absence of pain, symptoms or disease.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of both muscle and nerve function, and interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to function properly.

We do not offer to diagnose or treat any diseases 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. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

POLICIES

- All first visit charges are payable when services are rendered, if your visit is promotional or you have a gift certificate, please inform the front desk assistant.

EMERGENCY CONTACT

In case of emergency, notify: _____
Relationship: _____
Address: _____
Phone number(s):_____

Consent to evaluate and treat a minor child.

I _____ being the parent or legal guardian of _____

have read and fully understand the above policies and terms of acceptance, and hereby grant permission for my child to receive chiropractic services.

_____

Parent/Guardian Signature Date

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INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Parent/Guardian Name: _____ Signature: _____ Date:_____

Witness Name: _____ Signature: _____ Date:_____