PEDIATRIC HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ / _____ / _____ Work Phone: _____

Sex: _____ Weight: _____ Height: _____ Referred By: _____

Names of Parents / Guardians: _____

Purpose For Contacting Us ? _____

Other Doctors Seen for this Condition: _____ N _____ Y , Doctors' Names and Prior Treatments: _____

_____

Other Health Problems ? _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma / Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing / Back Pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ Other _____

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Are You Satisfied with the Care Your Child has Received There ? _____ N _____ Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications During Pregnancy ? _____ N _____ Y , List: _____

Ultrasounds During Pregnancy ? _____ N _____ Y , Number: _____

Medications During Pregnancy / Delivery ? _____ N _____ Y , List: _____

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction

_____ Ceasarian Section , Emergency or Planned ?

Complications During Delivery ? _____ N _____ Y , List: _____

Genetic Disorders or Disabilities: _____ N _____ Y , List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

Feeding History:

Breast Fed: _____ N _____ Y , How Long: _____

Formula Fed: _____ N _____ Y , How Long: _____ Type: _____

Introduced to Solids at: _____ Months , Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____ Y , List: _____

_____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit Up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Saftey Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child ? _____ N _____ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _____ N _____ Y , List: _____

_____

Has Your Child Ever Been Involved in a Car Accident ? _____ N _____ Y , List: _____

Has Your Child Been Seen on an Emergency Basis ? _____ N _____ Y , List: _____

Other Traumas Not Described Above ? _____ N _____ Y , List: _____

Prior Surgery: _____ N _____ Y , List: _____

Menarche: _____ N _____ Y , Age: _____

Childhood Diseases:

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Rubeola	N / Y, Age _____	Other	N / Y, Age _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: ____ / ____ / ____

Penn Chiropractic Centre

1905 Horton Road
Jackson MI 49203
(517) 784-7443
www.docpenn.com

Insurance Information

Patient Last Name _____ First Name _____ Middle _____

Insurance Type (Check all those that apply)

Self Insurance (Consumer Directed)

- ☐ Personal Health Insurance (not sponsored by employer)
- ☐ Health Savings Account (HSA)
- ☐ Other _____

Employee Sponsored (Private Sectors)

- ☐ Group Health Insurance
- ☐ Self Funded Benefit Plan
- ☐ Private Schools
- ☐ Health Reimbursement Arrangement (HRA)

Governments (Public Sectors)

- ☐ Medicare Part B
- ☐ Medicare Part C
- ☐ Medicaid
- ☐ Municipal (city, state, etc.)
- ☐ Other

Other Types

- ☐ Auto Injury
- ☐ Workers' Compensation
- ☐ Church
- ☐ Other _____

Insurance We need a copy of your cards for our records.

Insurance Company _____ Phone # ( ) _____
Insured's Name _____ ID/Policy # _____

Insurance Company _____ Phone # ( ) _____
Insured's Name _____ ID/Policy # _____

Insurance Company _____ Phone # ( ) _____
Insured's Name _____ ID/Policy # _____

Responsible Party Complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____
Relationship to Patient _____ SS# _____
Home Address _____ Apt# _____
City _____ City _____
Home Phone # _____ Work Phone # _____
Employer Name _____ Occupation _____

My Financial Responsibility

I certify that the above information is correct. I understand that I am personally, financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co payments, or non-covered services as may be required by my insurance plan.

_____ _____
Signature of patient or person acting on patient's behalf Date

My Authorization

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

_____ _____
Signature of patient or person acting on patient's behalf 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.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental and social well being, not merely the absences of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 these findings, we will recommend that you see the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. The Power That Made The Body Can Heal The Body.

Our only method is specific adjusting to correct vertebral subluxations.

Minor Release:
I, _____ Being the parent or legal guardian of _____ have read and fully understand the above Terms of Acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:
This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

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Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Dr. Randolph J. Penn's " Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Dr. Randolph J. Penn's " Notice of Privacy Practices" prior to signing this document. Dr. Penn's " Notice of Privacy Practices" has been provided to me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of Randolph J. Penn , D.C. The Notice of Privacy Practices for Randolph . Penn, D.C. is also provided on request at the main administration desk of his practice. This Notice of Privacy Practices also describes my rights and Dr. Penn's duties with respect to my protected health information.

Randolph J. Penn, D. C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

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Email Signup Form

Our office communicates to our patients via conventional mail and e-mail. Please provide your email address below. By doing so, you are giving Penn Chiropractic Centre, Dr. Penn, and staff permission to contact you via mail and e-mail. We will not sell, rent or give away your contact information to any outside entity.

E-mail Address _____

Full Name _____ Date _____

Signature _____