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 or 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: _____ BIRTH DATE: _____

ADDRESS: _____

WEIGHT: _____ HEIGHT: _____ MALE OR FEMALE: _____

PARENT NAME: _____ PARENT NAME: _____

HOME PHONE: _____ WORK PHONE: _____

INSURANCE COMPANY: _____ID NUMBER:_____

NAME OF INSURED: _____ INSURED'S DOB: _____

PURPOSE FOR YOUR VISIT: _____

OTHER DOCTORS SEEN FOR THIS CONDITION: ☐ YES ☐ NO DR'S NAME: _____

PRIOR TREATMENTS: _____

OTHER HEALTH PROBLEMS: _____

CHECK ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS SUFFERED FROM IN THE LAST 6 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 PEDIATRIC/FAMILY DOCTOR: _____

DATE OF LAST VISIT: _____ REASON: _____

ARE YOU SATISFIED WITH THE CARE YOUR CHILD RECEIVED THERE? ☐ YES ☐ NO

NUMBER OF ANTIBIOTICS YOUR CHILD HAS TAKEN:

IN THE PAST 6 MONTHS: _____ TOTAL DURING HIS/HER LIFE: _____ LIST: _____

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN:

IN THE PAST 6 MONTHS: _____ TOTAL OVERALL: _____ LIST: _____

VACCINATION HISTORY: _____

PRENATAL HISTORY:

NAME OF OBSTETRICIAN/MIDWIFE: _____

COMPLICATIONS DURING PREGNANCY? ☐ NO ☐ YES (IF YES) LIST: _____

ULTRASOUNDS DURING PREGNANCY? ☐ NO ☐ YES (IF YES) LIST: _____

MEDICATIONS DURING PREGNANCY/DELIVERY? ☐ NO ☐ YES (IF YES) LIST: _____

CIGARETTE/ALCOHOL USE DURING PREGNANCY? ☐ NO ☐ YES (IF YES) LIST: _____

LOCATION OF BIRTH: ☐ HOSPITAL ☐ BIRTHING CENTER ☐ HOME

BIRTH INTERVENTION: ☐ FORCEPS ☐ VACUUM EXTRACTION ☐ CAESARIAN SECTION, EMERGENCY OR PLANNED?_____

COMPLICATIONS DURING DELIVERY? ☐ NO ☐ YES (IF YES) LIST: _____

GENETIC DISORDERS OR DISABILITIES? ☐ NO ☐ YES (IF YES) LIST: _____

WEIGHT: _____ BIRTH LENGTH: _____ APGAR SCORES: _____

FEEDING HISTORY:

BREAST FED: ☐ NO ☐ YES (IF YES) HOW LONG? _____

FORMULA FED: ☐ NO ☐ YES (IF YES) HOW LONG? _____

INTRODUCED TO SOLIDS AT: _____ MONTHS OLD, COWS MILK AT: _____ MONTHS OLD

FOOD/JUICE ALLERGIES OR INTOLERANCES: ☐ NO ☐ YES (IF YES) LIST: _____

_____

DEVELOPMENTAL HISTORY:

DURING THE FOLLOWING TIMES YOUR CHILD'S SPINE IS MORE VULNERABLE TO STRESS AND SHOULD ROUTINELY BE CHECKED BY A CHIROPRACTOR FOR PREVENTION AND EARLY DETECTION OF VERTEBRAL SUBLUXATION (SPINE NERVE INTERFERENCE).

AT WHAT AGE WAS YOUR CHILD ABLE TO:

_____ RESPOND TO SOUND _____HOLD HEAD UP _____CROSS CRAWL _____WALK ALONE

_____ RESPOND TO VISUAL STIMULI _____SIT UP _____ STAND ALONE

ACCORDING TO THE NATIONAL SAFETY COUNCIL, APPROXIMATELY 50% OF CHILDREN FELL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E. BED, CHANGING TABLE, STAIRS, ETC).

WAS THIS THE CASE WITH YOUR CHILD? : ☐ NO ☐ YES (IF YES) LIST: _____

HAS YOUR CHILD EVER BEEN INVOLVED IN A CAR ACCIDENT? ☐ NO ☐ YES (IF YES) LIST: _____

HAS YOUR CHILD EVER BEEN SEEN ON AN EMERGENCY BASIS? ☐ NO ☐ YES (IF YES) LIST: _____

OTHER TRAUMAS NOT DESCRIBED ABOVE? ☐ NO ☐ YES (IF YES) LIST: _____

PRIOR SURGERY? ☐ NO ☐ YES (IF YES) LIST: _____

MENARCHE? ☐ NO ☐ YES (IF YES) LIST: _____

CHILDHOOD DISEASES:

CHICKEN POX	☐ NO ☐ YES	AGE_____	MUMPS	☐ NO ☐ YES	AGE_____
RUBELLA	☐ NO ☐ YES	AGE_____	WHOOPING COUGH	☐ NO ☐ YES	AGE_____
RUBEOLA	☐ NO ☐ YES	AGE_____	OTHER:_____	☐ NO ☐ YES	AGE_____

AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE FAMILY CHIROPRACTORS OF MONTCLAIR 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 SERVICES RENDERED BY THIS OFFICE.

_____ _____ _____

(PARENT/GUARDIAN PRINTED NAME) (PARENT/GUARDIAN SIGNATURE) (DATE)

I AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL RECORDS OR OTHER NECESSARY INFORMATION TO PROCESS CLAIMS. I ALSO REQUEST PAYMENT OF BENEFITS BE MADE DIRECTLY TO FAMILY CHIROPRACTORS OF MONTCLAIR. I AM CONSENTING TO SIGNING AN OPEN SIGN-IN SHEET EVERY VISIT ON BEHALF OF MY SON/DAUGHTER AND I UNDERSTAND THAT ANYONE WHO ENTERS THE OFFICE WILL BE ABLE TO VIEW HIS/HER NAME ON THIS SHEET. THE STATEMENTS MADE ON THIS FORM ARE ACCURATE TO THE BEST OF MY RECOLLECTION.

_____ _____ _____

(PARENT/GUARDIAN PRINTED NAME) (PARENT/GUARDIAN SIGNATURE) (DATE)

Family Chiropractors
39 Watchung Plaza
Montclair, NJ 07042
(973) 783-5666

Health Insurance Financial Policy

Since most health insurance plans have a deductible, you must pay 100% of your charges until your deductible is satisfied. Once you have met your deductible, we will accept authorization for direct payment of benefits to this office. You must provide us a copy of your health insurance card.

Upon receipt of this information, we will contact your company to verify the eligibility of chiropractic benefits. All information provided to us by your insurance company included any policy limitations or exclusions will be discussed with you. Since most health insurance plans do not reimburse health care expenses 100%, you may be responsible for your co-payment/co-insurance. CO-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.

Patients selecting this option understand this office submits bills and awaits direct payment from insurance companies as a courtesy, and that in no way relieves patients of their financial responsibility to this office. If your insurance company denies or delays reimbursement to this office for any reason, the allowable expenses are your responsibility. MONITORING ANY POLICY LIMITATIONS IS CONSIDERED THE RESPONSIBILITY OF THE PATIENT.

I authorize all insurance companies, third party payers and attorney's to make direct payment of my benefits to Family Chiropractors of Montclair for all monies due to my account for the services I have received. If my policy prohibits assignment, I direct my insurance company to mail all checks made payable to me, directly to Family Chiropractors of Montclair at 39 Watchung Plaza, Montclair, NJ 07042.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

PATIENT'S ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT FAMILY CHIROPRACTORS OF MONTCLAIR IS PERMITTED BY LAW, TO USE MY PERSONAL HEALTH INFORMATION, TO FACILITATE PAYMENT OF ANY FEES AND EXPENSES. FAMILY CHIROPRACTORS OF MONTCLAIR HAS AGREED TO ASSIST ME IN BILLING, MY HEALTH INSURANCE, AUTO INSURANCE AND ANY AND ALL OTHER APPLICABLE COLLATERAL SOURCES, AND ALTHOUGH THE PRACTICE WILL AWAIT THEIR DIRECT PAYMENT, I AGREE I AM FULLY AND PERSONALLY RESPONSIBLE, FOR ALL FEES I INCUR IN CONNECTION WITH SERVICE RENDERED FOR THE PURPOSE OF TODAY'S ENCOUNTER, AS WELL AS ANY FUTURE SERVICES, FOR ANY CONDITIONS, KNOWN OR AS OF YET UNKNOWN.

I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT. I HEREBY AUTHORIZE FAMILY CHIROPRACTORS OF MONTCLAIR TO PROVIDE ME WITH CHIROPRACTIC CARE IN ACCORDANCE WITH THE STATE'S STATUTES.

Patient Signature_____ **Date:**_____

STATEMENT OF NON-ACCIDENT

I,_____, am currently receiving chiropractic care at this facility. Please know that this care is **not related** to any auto accident, worker's compensation injury, or any other type of injury in which there is a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this chiropractic office. If you have any questions, do not hesitate to contact me personally.

_____ _____

Print Name Signature

HIPPA FORM

We are required by State and Federal Law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the rights to alter or amend the terms of this privacy notice. IF changes are made to our privacy notice we will notify you, in writing, as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to:

Dr. Luis Mizraji. Privacy Officer
If you would like further information about our privacy policies and practices, please contact:

Dr. Luis Mizraji. Privacy Officer
You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.
This notice is effective as of the date of execution listed below. This notice, and any alterations or amendments made here to will expire seven years after the date upon which the record was created. My signature acknowledges that I have read through this document and that upon my request I have received a copy of this notice for my personal records.

_____ _____ _____

Name (please print) Signature Date

If you are a minor, your parent or guardian must sign or in the event of other representation issues, please have the following executed by the appropriate representing party.

_____ _____ _____

Personal Representative (please print) Personal Representative Signature Date