Pediatric Intake Form

Personal Information Date: / /

Person Filling Out Form: _____ **Relationship:** _____

Child's First Name: _____ **Last Name:** _____

Preferred Name: _____ **DOB:** _____/_____/_____ **Sex: M / F**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Parent Names: _____

Marital Status: Married Divorced Separated Remarried

Phone Numbers: (_____)_____-_____Mother/Father H/W/C Provider:_____

(_____)_____-_____Mother/Father H/W/C Provider:_____

Email Address: _____ **Mom / Dad**

Alternate/Emergency Contact: _____

Relationship: _____ **Phone Number: (_____)_____-_____ H/W/C**

Who may we thank for referring you to Midwest Family Wellness? _____

Insurance Coverage Yes / No Subscriber's Employer: _____

Subscriber: _____ **DOB:** _____/_____/_____ **SSN:** _____

Insurance Company: _____

Policy#: _____ **Grp#:** _____

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www.mfwellness.org

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Reason For Seeking Chiropractic Care

Has your child had previous chiropractic care? Yes / No When: _____/_____/_____

Why are you seeking care today? _____

When did this begin? _____

Has your child had any major accidents or falls? If so, when and circumstances?

_____

_____

How has this affected your child's daily activities?

_____

Have you seen any other providers?

_____

Child's PCP: _____ Phone #: ( ) _____-_____

Date of Last Physical Examination: _____/_____/_____ Height: _____ Weight: _____

Any concerns at the last physical? _____

HEALTH CONCERNS

- **Anxiety/Depression**
- **ADD/ADHD**
- **Autism**
- **Other behavioral/Learning Disorders**
- **Irritability/Nervousness**
- **Bed Wetting**
- **Constipation/Diarrhea**
- **Nausea/Vomiting**
- **Frequent Stomach Aches**
- **Diabetes**
- **Weight Issues (Losing/Gaining)**
- **Fatigue/Sleep Issues**
- **Asthma/Bronchitis/RSV/Pneumonia**
- **Colic/Acid Reflux**
- **Back/Neck Pain/Stiffness**
- **Ear/Throat Infections**
- **Headaches**
- **Sinus Trouble**
- **Allergies (Food/Seasonal)**
- **Other _____**

Medications: _____

Vitamins/Supplements: _____

Explanations for checked boxes: _____

_____

Surgeries/Hospitalizations: _____

Pregnancy/Delivery

Midwest Family WELLNESS

Were there any complications during pregnancy or delivery? Yes / No

Type of delivery: _____ How long was labor? _____

Were forceps or a vacuum used? Yes / No Was there any twisting or pulling? Yes / No

Explanation for any "Yes" answers: _____

_____

Lifestyle

What sports does your child play? _____

How often do they practice? _____

Have they had any injuries due to sports? _____

Tablet or phone time? Yes / No How much? _____ TV time per day? _____

Does your child have a balanced diet? Yes / No
How much water do they drink per day? _____

Does your child balance school/extracurricular/social situations well? _____

Do you have any concerns you wish to discuss? _____

_____

Permission to treat a minor

I, (parent/guardian) _____, give Midwest Family Wellness

permission to examine, x-ray (if necessary), and treat _____,

DOB ____/____/_____.

Parent /Guardian Signature: _____ Date: ____/____/_____

HIPAA Consent

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view changes to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. I authorize the use of my full name for the purpose of greeting me, announcing me into a room, or around the office in the presence of others. This is effective as of January 2, 2003, and remains in effect until further notice.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third-party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understood the Notice of Privacy Practices. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date: ____/____/____ Patient Name: _____ Signature: _____

Relationship to Patient: _____

People Authorized to Obtain Medical Information: _____

Financial Policy

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal we need your commitment as well.

- **We urge you to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office as soon as possible to make any changes. In order to obtain the level of achievement we both desire, care must be followed.**
- **I authorize Midwest Family Wellness to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.**
- **We will bill your insurance for all procedures completed in our office. Your insurance may or may not cover all of these services. We do not cater our care to what your insurance covers, but by what the doctors feel is necessary to correct any vertebral subluxations we find. Although your benefits may show that a procedure is covered it is not a guarantee of payment. We will always submit any information which your insurance may request in order to have your claims paid. However, you will be responsible for any amount which your insurance does not cover, unless a prior agreement between you and Midwest Family Wellness exists. Payment will be expected within 30 days of notification of the amount due.**
- **Should insurance payments be remitted to you, the patient, in the form of PR 100's, those payments will need to be submitted to Midwest Family Wellness immediately.**
- **Midwest Family Wellness is a provider with Medicare. After you have met your deductible, Medicare Part B pays for a portion of the visits when you are adjusted only if you have first had an exam and x-rays.**
- **All charges are to be paid by cash, check or credit card before services are rendered. We do not bill for services rendered.**
- **You are expected to make us aware of any changes to your insurance.**
- **If you have any questions about our financial policies, please ask to speak to our financial officer. If you need to make special arrangements, please ask. We will do everything possible to make sure your chiropractic care fits into your budget.**

Patient Name: _____ Signature: _____ Date: _____