Family Chiropractic Center of Bayonne

Dr. Noah De Koyer

734 Broadway | Bayonne | New Jersey 07002
Phone: 201-437-0033 | Fax: 201-858-4049
Email: ndekoyer@hotmail.com | website: www.FCCofBayonne.com

PEDIATRIC PATIENT INTRODUCTION

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS

CHILD'S NAME: _____ MOTHER'S NAME: _____

SOCIAL SECURITY#_____FATHER'S NAME: _____

PHONE NUMBER: _____

ADDRESS: _____

BIRTH DATE: _____ AGE: _____ BIRTH WEIGHT: _____ CURRENT WEIGHT: _____

TYPE OF BIRTH: NORMAL VAGINAL ☐ FORCEPS ☐ BREECH ☐ CESAREAN ☐

HOME ☐ BIRTHING CENTER ☐ HOSPITAL ☐ APGAR SCORES: _____

WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW) ☐ CYANOSIS (BLUE) ☐

PROBLEMS DURING PREGNANCY? _____

PROBLEMS DURING LABOR/DELIVERY? _____

CONGENITAL ANOMALIES/DEFECTS: _____

INFANT FEEDING: BREAST ☐ BOTTLE ☐ FORMULA ☐

NUMBER OF HOURS SLEEP PER NIGHT: _____ QUALITY OF SLEEP: GOOD ☐ FAIR ☐ POOR ☐

OBSTETRICIAN/MIDWIFE: _____
(NAME) (LOCATION)

PEDIATRICIAN/FAMILY MD_____
(NAME) (LOCATION)

DATE OF LAST VISIT TO MD: _____PURPOSE OF VISIT_____

IMMUNIZATION HISTORY: _____

PURPOSE OF THIS APPOINTMENT: _____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? YES ☐ (PLEASE DESCRIBE BELOW) NO ☐

DESCRIBE_____

_____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR (S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

SIGNED_____WITNESSED_____DATE_____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED.

DATE: _____ SIGNATURE: _____

PREGNANCY HISTORY: _____

_____

_____

_____

_____

_____

DELIVERY / BIRTH HISTORY: _____

_____

_____

_____

_____

_____

DEVELOPMENT HISTORY: AT WHAT AGE DID CHILD:

RESPOND TO SOUND: _____FOLLOW OBJECTS WITH EYES: _____HOLD HEAD UP: _____

SIT ALONE: _____CRAWL: _____STAND: _____WALK ALONE:_____

CHILDHOOD DISEASES: CHICKENPOX: YES ☐ NO ☐ RUBELLA: YES ☐ NO ☐

MUMPS: YES ☐ NO ☐ MEASELS: YES ☐ NO ☐ WHOOPING COUGH: YES ☐ NO ☐

OTHER: YES ☐ NO ☐

HAS THIS CHILD EVER SUFFERED FROM:

☐ Allergies	☐ Chronic earaches	☐ "Growing Pains"	☐ Paralysis
☐ Anemia	☐ Colds/Flu	☐ Headaches	☐ Poor appetite
☐ Arm problems	☐ Constipation	☐ Heart trouble	☐ Rheumatic fever
☐ Arthritis	☐ Convulsions	☐ Hyperactivity	☐ Ruptures / Hernias
☐ Asthma	☐ Depression	☐ Hypertension	☐ Sinus trouble
☐ Backaches	☐ Diabetes	☐ Joint problems	☐ Stomach aches
☐ Bed wetting	☐ Diarrhea	☐ Leg problems	☐ Sugar concentration
☐ Behavioral problems	☐ Digestive disorders	☐ Neck problems	☐ Tuberculosis
☐ Blood disorders	☐ Dizziness	☐ Neuritis	☐ Walking problems
☐ Broken bones	☐ Fainting	☐ Orthopedic problems	☐ Other

PRESENT HISTORY:_____

_____

_____

SURGERY:_____

MEDICATIONS:_____

ACCIDENTS:_____

FAMILY HISTORY:_____

_____

_____

Family Chiropractic Center of Bayonne's Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Family Chiropractic Center of Bayonne** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of **Family Chiropractic Center of Bayonne**. I understand that diagnosis or treatment of me by the doctors and practitioners of the **Family Chiropractic Center of Bayonne** may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Family Chiropractic Center of Bayonne** is not required to agree to the restrictions that I may request. However, if **Family Chiropractic Center of Bayonne** agrees to a restriction that I request, the restriction is binding on **Family Chiropractic Center of Bayonne** and its doctors and practitioners. I have the right to revoke this consent, in writing, at any time, except to the extent that the doctors and practitioners of the **Family Chiropractic Center of Bayonne** have taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review **Family Chiropractic Center of Bayonne's** Notice of Privacy Practices prior to signing this document. The **Family Chiropractic Center of Bayonne's** Notice of Privacy Practices is available at the front desk. 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 operations of the **Family Chiropractic Center of Bayonne**. The Notice of Privacy Practices for **Family Chiropractic Center of Bayonne** is also provided on the wall in the waiting area and on **Family Chiropractic Center of Bayonne's** website at www.fccofbayonne. This Notice of Privacy Practices also describes my rights and the **Family Chiropractic Center of Bayonne's** duty with respect to my protected health information. **Family Chiropractic Center of Bayonne** 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 accessing the **Family Chiropractic Center of Bayonne's** website, 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

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority