Family Chiropractic Center of Bayonne

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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. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC.

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