ACTIVE LIFE CHIROPRACTIC

12920 Lebanon Rd. Mt Juliet, TN 37122
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Childs Patient Profile

Full Name: ____________________________________

Birthdate: ____/_____/____ Gender: M F
mm dd yy

Address: ____________________________________

____
City State Zip Code

Parent Name: ____________________________________

Parent Phone: ____________________________________

Parent Email Address: ____________________________________

Parent Occupation: ____________________________________

Referred By: ____________________________________

Health insurance? No Yes

If yes, Insurance Company:_______________

Responsible party: Parent Other: _________

Health savings account account? No Yes

Health History I

List of prescriptions, over-the-counter medications, vitamins or supplements child currently takes:

______________________ ______________________

______________________ ______________________

Does your child have any allergies? N Y: ______________

For Children under 6________________________________

During pregnancy did the mother:

- ☐ Take medication
- ☐ Smoke
- ☐ Drink Alcohol
- ☐ Experience Illness

Was labor:

- ☐ chemically induced
- ☐ C-Section
- ☐ Premature
- ☐ vacuum/forceps
- ☐ Dr pull baby during delivery

Immediately after birth did child experience:

- ☐ Displaced or broken joint
- ☐ Feeding problems
- ☐ Respiratory problems
- ☐ Other_______________

Is/was your child breastfed? N Y

Reason for Visit

Reason for child's visit: ____________________________________

____

When did the symptoms begin: ____________________

Related to:

- ☐ Sports
- ☐ Auto
- ☐ Fall
- ☐ Chronic
- ☐ Home Injury
- ☐ Other ____________

How is it affecting your child's quality of life?

- ☐ School
- ☐ Playing
- ☐ Communication
- ☐ Exercise/Sports
- ☐ No change
- ☐ Sleep
- ☐ Eating
- ☐ Walking
- ☐ Attention/Focus
- ☐ Daily Routine

Please check all that apply to your child:

- ☐ Severe Trauma
- ☐ Auto accident
- ☐ Surgery
- ☐ Hospitalized
- ☐ Uncoordinated / Accident prone
- ☐ Chronic illness
- ☐ Fractured bone or dislocated joint

Has your child seen other dr's for this condition? N Y

Doctor _______________ Treatment _________________

Has your child received chiropractic care before? N Y

Reason _______________ How long ___________________

Why was care stopped? ______________________________

Health History II

Does the child currently have or previously had the following conditions? While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and course of care for your child.

- ☐ Vision Problems
- ☐ Headaches
- ☐ Irritability
- ☐ Sleeping Disorders
- ☐ Allergies
- ☐ Skin Problems
- ☐ Ear Problems
- ☐ Tubes in Ears
- ☐ Frequent Colds
- ☐ Hyperactivity
- ☐ Asthma
- ☐ Constipation
- ☐ Bed Wetting
- ☐ Colic
- ☐ Digestive Issues

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

Consent to Perform and Interpret X-rays The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records The patient hereby assigns benefits to be paid directly to this provider by all of the third party payors. This assignment is irrevocable. Failure to fill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation and Appointment Policy **The patient accepts full financial responsibility for services rendered by this practice.** An account which is past due and for which no payment arrangements have been made will be forwarded to a collection agency. Collection agency fees will be the responsibility of the patient.

Initial _____

______________________	______________________
Patient Name	Parent / Legal Guardian Name
______________________	______________________
Parent / Legal Guardian Signature	Date