Ontario Chiropractic

200 SW 2nd Avenue ~ Ontario, OR

Pediatric Health History Form

Child's Information

Name

Address

City State/Zip

Home Telephone

Date of Birth Age

Social Security Number

Gender Height Weight

Parent / Guardian Information

Parent Name

Address ☐ Same as Above

City State/Zip

Home Phone Cell Phone

Employer Name

Employer Address

Employer City Employer State/Zip

Work Phone Occupation

Insurance Information

Insurance Company

Insured's Name

Insured's Social Security Number

Insured's Date of Birth

Pediatrician Information

Name of Pediatrician or Family Doctor

Telephone of Doctor

Please list any other doctors or specialists your child sees

Reason for this Visit

Describe the reason for this visit:

Is this due to an injury? ☐ Yes ☐ No

If yes, please explain:

When did the condition or symptoms begin?

Has your child had these symptoms before? ☐ Yes ☐ No

Please explain:

Have you seen other doctors for this condition? ☐ Yes ☐ No

Please list:

Has the condition

☐ gotten better ☐ gotten worse ☐ come & gone ☐ stayed same

Vaccination Information

Have you chosen to vaccine your child? ☐ Yes ☐ No

If yes, check all that apply:

☐ Hep A ☐ Hep B ☐ DTaP ☐ Hib ☐ PCV ☐ IPV

☐ MMR ☐ Influenza ☐ Varicella ☐ MCV ☐ Other:

Describe any & all reactions:

Health History *Please check each of the conditions that the child now has or has had in the past.*

☐ Allergies	☐ Constipation	☐ Irritability
☐ Asthma	☐ Digestive Problems	☐ Skin Problems
☐ Attention Problems	☐ Ear Problems	☐ Sleeping Disorders
☐ Bed Wetting	☐ Frequent Colds	☐ Tubes in Ears
☐ Breathing Problems	☐ Headaches	☐ Vision Problems
☐ Chicken Pox	☐ Whooping Cough	☐ Mumps
☐ Scoliosis	☐ Seizures	☐ Back or Neck Pain
☐ Colic	☐ Hyperactivity	☐ Other:

Current Health Status

Has your child ever been hospitalized? ☐ Yes ☐ No
Please explain:

Has your child ever had surgery? ☐ Yes ☐ No
Please explain:

Is your child currently taking medications? ☐ Yes ☐ No
If yes, please list:

If no, has your child ever taken medications in the *past* for an extended period of time? ☐ Yes ☐ No
Please explain:

Has your child ever taken antibiotics? ☐ Yes ☐ No
Please explain why and how often:

Does your child take any supplements/vitamins? ☐ Yes ☐ No
Please list:

Is your child involved in contact sports? ☐ Yes ☐ No
Please list:

Has your child ever had a concussion? ☐ Yes ☐ No

Has your child ever been in a car accident? ☐ Yes ☐ No
Please explain:

Has your child ever fallen from a high place (down stairs, from a tree, changing table, etc.)? ☐ Yes ☐ No
Please explain:

Please describe any concerns that you have about your child's development, health or behavior:

Mother's Pregnancy & Labor

During pregnancy, did you use:
☐ Drugs / Medications ☐ Tobacco ☐ Alcohol

Describe your delivery:
☐ Labor was chemically induced ☐ Labor was doctor assisted
☐ C-section Delivery ☐ Forceps / Vacuum used
☐ Doctor had to pull/twist baby ☐ Premature Delivery
☐ Normal, uncomplicated delivery ☐ Other: (please explain)

Did you experience any illness(es) while pregnant?
☐ Yes ☐ No
Please explain:

Please list medications taken during pregnancy:

Did you nurse the baby? ☐ Yes ☐ No

X-ray Agreement

It is understood and agreed that the payments to the clinic for x-rays is for examination of the x-rays only. The x-ray films will remain the property of this clinic, as mandated by state rule. The doctors/staff agree to make your x-rays available to you or to any doctor or clinic within 30 days of a signed request, as regulated by Oregon Administrative Rule 847-012-000.

Signature of Parent or Guarantor

_____

X-ray Consent (Women Only)

X-rays can be harmful to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to x-rays if recommended by the doctor.

Signature of Patient

_____

Authorization for Care of a Minor

I hereby authorize the doctor to administer chiropractic care to the child listed in these forms as the doctor deems appropriate.

Signature of Parent or Guarantor

_____

Printed Name of Parent or Guarantor

_____

Date

_____

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Informed Consent for Treatment

Informed Consent / Consent for Care

_____I have been informed of the nature, purpose and scope of care to be provided by the doctors of Ontario Chiropractic, the possible limitations and consequences of that care, and the possibility that the care given by Ontario Chiropractic may not help or resolve my complaint, dysfunction or condition.

_____I consent to care and recommendations made by the doctors of Ontario Chiropractic for myself (or my children, if minors) including, but not limited to examinations, x-rays, chiropractic adjustments, adjunctive therapies (including massage, traction, hot or cold application) and rehabilitation.

_____I understand that my care will be individualized and therefore may not be comparable with standards or guidelines required by insurance companies, Medicare, professional associations and/or consensus groups.

_____I understand that my treatment will comply with the standard of care defined by the laws in the state of Oregon.

_____I recognize that all health care procedures, including those used in this clinic, have risks associated with them. Risks, although rare, associated with chiropractic adjusting procedures, may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome, including cerebrovascular accident (stroke) or death through complicating factors.

I hereby accept the risks associated with any care by the doctors and staff of Ontario Chiropractic and release them of any liability for any injury or loss directly related to care I have received at this clinic. In the event of emergency, I grant the doctors and staff of Ontario Chiropractic permission to provide emergency care and any follow-up necessary, including referral to Emergency Medical Services.

I am signing this consent and acceptance of terms after having been fully informed to my satisfaction of the risks and benefits of proceeding with care. I have been informed and fully understand that there are no guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Ontario Chiropractic.

_____

Patient Name (please print)

_____

Patient Signature *Date*

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Acceptance of Terms

Statement of Acknowledgement of Financial Responsibility

_____I understand that I am responsible for any charges incurred at this office, including co-pays, deductibles, and any services denied or not covered by my insurance company. The filing of insurance claims is a courtesy that we extend to our patients; however, all charges are strictly your responsibility. **I agree to be personally and fully responsible for payment of any denied or non-covered charges.**

_____I understand that it is my responsibility to know the coverage for chiropractic care provided by my specific insurance company and plan, including deductibles, co-pays and non-covered services. (Although we are contracted with several insurance companies, it is your responsibility to know the benefits for your specific health plan, including deductibles, co-pays, etc. We will assist you in any way we can to help make this process as smooth as possible, but we do not guarantee insurance coverage.)

_____I authorize the release of my records as necessary for billing purposes.

_____At the time of service, you will be responsible for any fees, co-pays, co-insurance, deductibles and non-authorized or non-covered services. For your convenience, we accept cash, checks, Visa and MasterCard. Special payment arrangements may be made by contacting the office manager. You will receive a monthly statement if there is a balance owed. A 1.5% monthly interest may be applied to all past due accounts that become uncollectible. In the event of nonpayment to Ontario Chiropractic, the balance may become due and payable in full and may be referred to a collection agency or to an attorney for legal action. By signing, you agree to pay for any reasonable court costs, attorney's fees and other applicable costs of collection. Any claim filed for the purpose of collection will be filed under the jurisdiction governing claims for the address of Ontario Chiropractic indicated above.

Auto & Work Related Injuries:

_____ Billing will be submitted to the appropriate insurance provider. In the event that my claim is rejected, I understand that I will be liable for all charges and expenses related to my care. (If your injury claim is rejected, Ontario Chiropractic agrees to bill your personal health insurance provider for compensation.)

Use and Disclosure of Health Care Information:

_____Ontario Chiropractic may collaborate with other providers to coordinate, manage and provide optimal care. This consent may include the release of written records, electronic health records (EHR), x-rays and x-ray reports, diagnoses (including sensitive information, such as HIV or sexually transmitted diseases, substance abuse, mental health information, etc.). I agree that Ontario Chiropractic may use and disclose my health information for a range of purposes such as: treatment, eligibility verification, collection, communications with payors (including your insurance, Workers' Compensation programs, etc.), quality of care assessment (such as internal reviews or insurance reviews, audits, etc.), and public health and health oversight services (when reporting is required by state or federal law).

_____I consent to Ontario Chiropractic's request for health information from other providers of care, whether written, verbal or electronic, for the uses described above.

_____I understand that a copy of the written Privacy Policy for Ontario Chiropractic is available upon request.

Signing below indicates that you have read and understand your obligations for payment for all services provided by the doctors and staff of Ontario Chiropractic.

_____

Patient Name (please print)

_____

Patient Signature *Date*

Insurance Information

Personal Insurance: *Please note that we do not provide billing to secondary insurance companies. If you have a secondary insurance provider, please ask the receptionist how to collect reimbursement for your care.*

Patient's name:_____ Policy Holder:_____

Employer of Policy Holder:_____ Employer Phone #:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Insurance Co.:_____ Ins. Phone #:_____

Insurance Address:_____ City:_____ State:_____ Zip:_____

Ins. ID / Policy #:_____

Workers Compensation Insurance: Date of Accident / Injury:_____

Patient's name:_____ Employer:_____

Work Comp Carrier:_____ Ins. Phone #:_____

Insurance Address:_____ City:_____ State:_____ Zip:_____

Ins. ID / Policy #:_____ Claim #:_____

Auto Injury Insurance:

Patient's Insurance Information

Patient's name:_____ Policy Holder:_____

Insurance Co.:_____ Ins. Phone #:_____

Insurance Address:_____ City:_____ State:_____ Zip:_____

Ins. ID / Policy #:_____ Claim #:_____

Date of Accident: _____ Location of Accident (State): _____

Other Party's Insurance Information (if applicable)

Policy Holder:_____

Insurance Co.:_____ Ins. Phone #:_____

Insurance Address:_____ City:_____ State:_____ Zip:_____

Ins. ID / Policy #:_____ Claim #:_____

. . . . . .

I authorize the doctor to furnish my attorney and/or insurance company with any necessary documentation related to my treatments at Ontario Chiropractic relating to the injury listed above.

I hereby give a lien to the my treating doctor at Ontario Chiropractic on any settlement, judgment, or verdict as a result of my injury and authorize and direct you, my attorney / insurance provider, to pay directly to my doctor any sums due him/her for services rendered me, and to withhold such sums from any settlement, judgment, or verdict as necessary to protect my doctor adequately.

_____

Patient Signature (or guardian) Date