Alpha Chiropractic

125 Slate Dr, Suite 1 Bismarck ND 58503

PEDIATRIC HISTORY FORM

Today's Date: ____ /____ /_____

Name: _____ Sex: _____ Birth Date: ____ /____ /_____

Name of Parents/Guardians:_____ Height: _____ Weight: _____

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

Cell Phone #: _____

Home Phone #: _____

Insurance Provider: _____

☐ Deductible ☐ Co-pay ☐ Unsure, please check for me

Pediatrician: _____

Date of Last Visit (approx):_____

Reason: _____

Has child been adjusted by a chiropractor before?

☐ No ☐ Yes;

Date of Last Visit (approx): _____

Current Medications:

☐ Antibiotics (please indicate number of prescriptions)

During past 6 months: _____ Total in Lifetime: _____

☐ Prescription Meds

Type/Purpose: _____

☐ Other(s): _____

How did you hear about our office?

☐ Referred by (name):_____

☐ Community Event:_____

☐ Saw Sign/Clinic ☐ Google ☐ Bing ☐ Yellowpages.com

☐ Newspaper ☐ Insurance ☐ Facebook ☐ Other

PRIMARY COMPLAINT/CONCERN: _____

When did this begin?_____ Cause (if known): _____

What makes this better?_____ What makes this worse?_____

Has this occurred before? ☐ No ☐ Yes; Explain: _____

Has child had any past treatment for this concern?

☐ No ☐ Yes; Type(s) of treatment: _____

Results: _____

ADDITIONAL HEALTH CONDITIONS/CONCERNS (PAST AND PRESENT)

☐ Ear infections
☐ Chronic colds
☐ Recurring fevers
☐ Asthma
☐ Allergies
☐ Colic
☐ Scoliosis
☐ Digestive problems
☐ Bed wetting
☐ Seizures
☐ ADD/ADHD
☐ Temper Tantrums
☐ Headaches
☐ Growing/Back Pains
☐ Genetic Disorders
☐ Accidents/Traumas (falls, auto accidents, etc)
☐ Hospitalizations/Surgeries
☐ Major Illnesses
☐ Reoccurring Illnesses
☐ Premature Birth
☐ Complications during Pregnancy or Delivery
☐ Other_____

Additional Information on any Checked Condition:

_____

_____

_____

_____

_____

_____

_____

_____

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FAMILY HEALTH HISTORY

A. Grandmother
B. Grandfather
C. Father
D. Mother
E. Aunt/Uncle
F. Sibling (s)
G. Spouse
H. Child

Please check each of the health conditions that a family member has now or has had in the past. Next to any checked box, please insert the corresponding letter to indicate the family member(s) affected by the condition.

- ☐ Headaches
- ☐ Neck/Back pain
- ☐ Diabetes
- ☐ Asthma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Alcohol/drug abuse
- ☐ Depression
- ☐ Anxiety
- ☐ Seizures
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Other _____
- ☐ Other _____

PATIENT AUTHORIZATION

The statements made on this form are accurate to the best of my recollection and I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. I understand that health and accident insurance policies are an arrangement between myself and my insurance provider. The office does work with insurance companies directly by submitting forms, claims, and notes for reimbursement on behalf of the patient; the amounts authorized to be paid directly to the Doctor's Office will be credited to my account on receipt from insurance companies. In the event that an account becomes delinquent and a collection agency and/or law office is needed to collect on the account, the patient is responsible for all collection costs and/or attorney fees.

Parent/Guardian Signature: _____ Date: _____

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HIPAA CONSENT FORM

I consent to the use or disclosure of my protected health information by Dr. Watkins and his staff for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations. I understand that analysis, diagnosis or treatment of me by Dr. Watkins may be conditioned upon my consent as evidenced by my signature below.

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. Dr. Watkins is not required to agree to the restrictions that I may request. However, if he agrees to a restriction that I request, that restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Watkins has taken action in reliance on this consent.

My "protected health information" means health information, including my demographics information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare 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 indentify me.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices*, and I understand that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.* 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 healthcare operations by Dr. Watkins. This *Notice of Privacy Practices* also describes my rights and the duties of Dr. Watkins with respect to my protected health information.

I also have been informed that Dr. Watkins and his staff may need to contact me occasionally by phone. By signing this form, I am giving them authorization to leave a message on my answering machine or with a family member if I am not available.

Dr. Watkins 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 calling the office of Watkins Family Chiropractic at 952-440-4553 and requesting a revised copy be sent in mail or asking for one at the time of my next appointment.

Patient Printed Name _____

Patient (or Guardian) **Signature:** _____ **Date:** _____

Description of guardian's authority: _____