BalancedBody chiropractic

Children's Form

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Please fill out completely.

CHILD'S PERSONAL INFORMATION

Today's Date:

Name: SSN:

Address: City: State: Zip:

Home Phone: Date of Birth: Age: Sex: ☐ Male ☐ Female

Parent/Guardian Name:

Employer: Work Phone: Cell Phone:

Child's Medical Doctor: Phone:

INSURANCE INFORMATION

Insurance Company Name: Phone:

Address: City: State: Zip:

Subscriber's Name: I.D. # Group #

Subscriber's DOB: Subscriber's Employer: Relation to Subscriber:

CHILD'S CONDITION

Reason for visit?

Is this related to: ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic ☐ Accident ☐ Other When did it begin?

Explain:

Is it getting worse? ☐ Yes ☐ No Is it constant? ☐ Yes ☐ No Similar condition in the past? ☐ Yes ☐ No

What treatments has your child received for this condition? ☐ None ☐ Medications ☐ Surgery ☐ PT ☐ Chiropractic ☐ Other

Does it interfere with: ☐ Daily Routine ☐ Recreation ☐ Sleep ☐ Other Explain:

CHILD'S HEALTH INFORMATION

Present Weight: Lbs. Present Height: Ft. In. Hours of sleep per night:

Were there any complications during Mom's pregnancy or delivery? ☐ Yes ☐ No

Explain:

Does your child have or ever had any of the following conditions? (Please check all that apply.)

☐ Vision Problems	☐ Skin Problems	☐ Constipation	☐ Attention Problems
☐ Headaches	☐ Breathing Problems	☐ Bed Wetting	☐ Colic
☐ Sleeping Disorders	☐ Asthma	☐ Pink Eye	☐ Frequent Colds
☐ Irritability	☐ Hyperactivity	☐ Ear Problems	☐ Digestive Problems

Other: Surgeries/Treatments:

Allergies: Medications:

CONDITIONS OF REGISTRATION

1. GENERAL CHIROPRACTIC CONSENT. The parent or the person legally authorized to consent for medical care on the child's behalf hereby consents to chiropractic care, including but not limited to spinal manipulation, rendered to the child under the general and special instructions of the chiropractor. I understand and am informed that, as with any healthcare procedure, in the practice of chiropractic there are some material risks inherent to treatment, including but not limited to fractures, disc injuries, dislocations and sprains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my child's best interest. However, if I know of a condition that would otherwise not come to the doctor's attention, it is my responsibility to inform the doctor. I accept full responsibility for treatment and I release Balanced Body Chiropractic and its doctors from any and all liability in the unlikely event that a problem occurs from my child's treatment.

2. RELEASE OF INFORMATION. To the extent necessary to determine responsibility for payment and to obtain reimbursement, Balanced Body Chiropractic may disclose pertinent portions of the child's medical or guarantor's financial records to insurance companies, health care service plans, worker's compensation carriers, corporations or persons who are or may be responsible for all or any portion of the child's account. Child's information may also be released to the referring physician and other health facilities to ensure continuity of care.

3. ASSIGNMENT OF INSURANCE BENEFITS. The parent or the child's legal representative authorizes payment directly to Balanced Body Chiropractic of any insurance benefits, both basic and chiropractic, otherwise payable to or on behalf of the child for all services rendered during the entire course of treatment and care by Balanced Body Chiropractic. I authorize the use of my signature on all insurance submissions.

4. FINANCIAL AGREEMENT. In consideration of the chiropractic services to be rendered, the parent or the guarantor signing hereby agrees to accept full financial responsibility for the child's account in accordance with the rates and terms of any contracts between Balanced Body Chiropractic, guarantor and the insurance company if Balanced Body Chiropractic contracts with the insurance company.

I, the undersigned, certify that all of the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever there are changes in my child's health condition or health plan coverage in the future. I have also read, or have had read to me, the above consent and had an opportunity to ask questions about its content, and by signing below I agree to and request chiropractic care for my child having been informed of the risks. I intend for this consent form to cover the entire course of treatment for my child's present condition and for any future condition(s) for which I seek treatment at Balanced Body Chiropractic.

Parent/Legal Guardian:

Print Name: _____ Relation: _____

Signature: _____ Date: _____

Doctor or Staff:

Witness Signature: _____ Date: _____