Wolph Chiropractic and Acupuncture

123 S. Main St. Fostoria, OH (419) 436-0616
640 S. Wintergarden Rd. Bowling Green, OH (419) 353-6394

Confidential Infant/Child Information

Date:___________________

Patient Name:____ D.O.B:___________________

Address:______________________________ City:________________ State:_____ Zip:________

Age:______________ Height:__________ Weight:______________ # of Siblings:____________

Name of MD/Pediatrician:____

Address:_______________________________________ Phone#:____________________________

Previous Chiropractor & Location:____

Date of last visit:______________ Reason for visit:__________________________________

Chief Compliant

Reason(s) for contacting us:____

List all prior treatment(s), medications, for compliant:____________________________

____

Date of onset:______________ Onset was: Sudden Gradual Duration of Issue:_____________

Effects of problem(s) on body function and daily activities:________________________

____

Prenatal History

Pregnancy normal? Yes No C-Section? Yes No Difficult labor/delivery? Yes No

Suction used for delivery? Yes No Were drugs used for delivery? Yes No

List any medications taken during pregnancy:____

Weight at birth:______________________

Developmental History

Any delays noticed? Yes No If yes list:____

____

Nutritional History

Breastfed:_________ months Formula age began:______________ for ____________ months

Began solid foods at age:__________ Any food/drink Allergies?_______________________

Child Health History

Immunizations: Yes No Social Behaviors? Yes No If Yes explain:______________________

____

List any or diagnosed conditions:____

____

List any medications past or current :____

____

Broken bones or surgeries:____

Other Significant Information

List family history (cancer, diabetes, heart disease, kidney disease etc): ______________________________

____

Photo Release

I **DO/DO NOT**, give my permission to have my child's picture displayed in the office, on our website, or on Facebook.

Parent/Guardian Information

Name: ______________________________ Address if different: ____________________

City: ____________________________ State: __________ Zip: ______________

Phone: ____________________ Cell: ____________________ Work: ____________________

SS#: ______________________________ Employer: ______________________________

List of people allowed to bring child to appointments: ______________________________

____

Health Insurance Information

Subscribers Name: ____________________________ D.O.B ____________ SS# ______________

Insurance Name: ____________________________ Employer: ______________________

Additional Insurance Coverage? Yes No (if yes, Please complete the following)

Subscribers Name: ____________________________ D.O.B: ____________ SS#: ______________

Insurance Name: ____________________________ Employer: ______________________

I hereby authorize Wolph Chiropractic, Inc to release any information concerning my child's condition to any insurance company, attorney, adjuster, or employer in order to process any claims for reimbursement of charges. In sigining below, I also give my permission for the insurance company to pay Wolph Chiropractic, Inc. directly.

Missed appointments

I understand that there may be a fee charged for any missed or canceled appointments prior to 24hr notice.

Communications

In the event that we would need to communicate your child's health information, to whom may we do so?

____

May we leave messages regarding your child's personal healthcare information on an answering device? (home answering machine, voicemail, etc) Yes ( ) No ( )

Acknowledgement/HIPAA

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my child's rights to privacy. Upon request I will be given 1 free copy, additional copies at a charge.

Should my account ever become delinquent I agree to be responsible for all Lawyer fees, court costs, and interest charges resulting in the filing of a small claims case for a collection of a debt incurred at Wolph Chiropractic, Inc. I also agree to be responsible for a $50 charge for all returned checks for "Insufficient funds" per incident.

Print Patient Name: ______________________________

Print Parent/Guardian Name: ______________________________

Signature of Parent/Guardian: ______________________________ Date: ____________