Pediatric History Form

Patient Name_____ SS#_____
Name of Parents / Guardians_____
Address _____City _____State _____Zip_____
Home Phone_____ Work Phone_____ Email Address_____
Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____
Who referred you to us? _____
Reason for seeking chiropractic care:_____
Other Doctors seen for this condition Y/N Specialty: _____
Prior treatment and outcome: _____
Other Health Problems: _____

Symptoms: Please check any current or past problems your child has on the list below:

_Dizziness
_ADHD
_Backaches
_Heart Condition
_Chronic Earaches
_Diabetes
_Tuberculosis
_Hypertension
_Fever/Chills
_Frequent Colds
_Arthritis
_Headaches
_Asthma

_Allergies
_Runny Nose
_Itchy Eyes
_Rashes
_Unusual Moles
_Neuritis
_Digestive
_Sinus Trouble
_Cough/Wheeze
_Chest Pain
_Constipation
_Anemia
_Rheumatic Fever

_Diarrhea
_Poor Appetite
_Hyperactivity
_Behavioral
_Poor Memory
_Insomnia
_Nightmares
_Bed Wetting
_Pain Urinating
_Convulsions _Paralysis
_Muscle Pain
_Fainting

_Broken bones
_Sprains/Strains
_Hernias
_Neck Pain
_Arm/Elbow Pain
_Leg/Hip Pain
_Knee/Foot Pain
_Growing pains
_Joint Pain
_Scoliosis
_Blood disorders
_Stomach Aches _Other

Health History:
Name of Pediatrician: _____ Date of last visit _____
Reason for visit: _____
Medications and conditions being treated: _____
Has your child ever taken antibiotics? Y/N Condition treated: _____
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N
If yes, describe (Sprain, Broken Bone, Head Trauma…) _____
Has your child ever been involved in a car accident? Y/N Date & Injuries _____
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N _____
Other traumas not described above? Y/N Type & Date: _____
Prior surgery: Y/N Type and Date:_____ Menarche: Y/N Age:_____

Prenatal History
Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted
Complications during pregnancy: Y/N List: _____
Ultrasounds during pregnancy: N Y Number: _____
Medications during pregnancy/delivery: Y/N List: _____
Cigarette / Alcohol use during pregnancy: Y/N
Birth intervention: O Forceps O Vacuum O Caesarian, Why?_____
Complications during delivery: Y/N List: _____
Genetic disorders or disabilities: Y/N List: _____
Birth weight_____ Birth length_____ APGAR scores: 1 min ____ 5 min ____

Feeding history
Breast Fed: Y/N How long'?_____ Formula fed: Y/N How long'?_____
Type:_____ Introduced to solids at _____ months. Cow's milk at _____ months
Food / juice allergies or intolerances Y/N List: _____

Developmental History
Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____

At hat age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

Childhood Diseases

O Chicken Pox - Age ___ O Mumps - Age ___ O Rubella - Age ___ O Whooping cough - Age ___

O Measles - Age ___ O Meningitis - Age ___ O Tuberculosis - Age ___ O Other - Age _____

Vaccination History:

O HBV / Hep B (Hepatitis B) – Age __ O MMR (Measles, Mumps, Rubella) – Age __

O DTP or O DTaP (Diphtheria, Tetanus, Pertussis) – Age __ O Varicella (Chicken Pox) – Age __

O HbCV / Hib (H. influenzae type b conjugate) – Age __ O PCV (Pneumoccocal) – Age __

O OPV (Oral Polio Vaccine) or O IPV (Inactivated Poliovirus) – Age __

Adverse Reactions to Any Vaccine? Y/N List: _____

Insurance

Do you have medical insurance? Y/N Insurance Company Name _____

Policy Number _____Insurance Company Phone number _____

Insured's Name _____Relationship to patient _____

Insured's DOB _____Insured's SS# _____

Insured's Employer _____ Insured's Employee Address_____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

I, _____, being the parent or legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

Signed _____Witnessed _____

Date _____

SILLITO CHIROPRACTIC CENTER, PS

PAYMENT POLICY

Thank you for choosing SILLITO CHIROPRACTIC CENTER as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. CONVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. MISSED APPOINTMENT. Our policy is to charge $25.00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing SILLITO CHIROPRACTIC CENTER as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered or approved by their insurance plan. Copays are due at the time of service. Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

PRINT PATIENT NAME:_____

PATIENTSIGNATURE:_____ DATE:_____

PARENT OR GUARDIAN must sign if patient is under 18 years of age

SIGNATURE:_____ DATE:_____

Derrol M. Sillito, D.C.

General Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby consent to the use and/or disclosure of my protected health information by Derrol M. Sillito, D.C. and staff for the purpose of Treatment, Payment, and Healthcare Operations. I understand that protected health information includes the following:

*All and any of my personal health records
*Demographic information
* Examination and test results
*Diagnosis
*Treatment
*Plans for future medical care

And that this information serves as:

* A means for communication among the many health care professionals who contribute to my care
* A source of information for applying my diagnosis and treatment information to my bill
* A basis for diagnosing, and planning my care and treatments
* A means by which a third party can verify that services billed were actually provided
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I further understand that:

*Derrol M. Sillito, D.C. originates and maintains protected health information as part of my healthcare including but not limited to information that may have been obtained from another healthcare provider, clearinghouse, health plan or employer
* I have the right to review Derrol M Sillito D.C. Notice of Privacy Practices before I sign this document.
* I have the right to request a restriction as to how my protected healthcare information is used carry out treatment, payment, or healthcare operations however, Derrol M. Sillito D.C. is not required to agree to the restriction request.
* I have a right to revoke this consent at anytime in writing. However it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.
* Derrol M. Sillito D.C. reserves the right to change their notice of privacy practices at anytime. I have the right to obtain a copy of any revised notice upon request.

Restrictions

[ ] No restrictions requested

[ ] I request the following restrictions on the use or disclosure of my health information

_____

_____

Patient Name:_____ Date_____

Patient Signature_____

Signature of Witness_____ Date_____