Confidential Patient Data

If you need any assistance completing this form, please ask the receptionist.

Legal First Name: _________________________ Middle Name _____________ Last Name: ______________________

Nickname: _______________________ Spouse's Name (if applicable) ____

SSN: ______________ ❍ Female ❍ Male Date of Birth: ____/_____/______ E-Mail Address: ____________________

Mailing Address: _________________________ City: ______________________ State: _______ Zip: ________________

Home Phone: (_____)_______________ Work Phone: (_____)________________ Cell Phone: (_____)________________

Employment Status: ❍ Full-Time ❍ Part-Time ❍ Retired ❍ Un-Employed ❍ Child ❍ Disabled ❍ Homemaker

Occupation Type: ________________________ Employer's Name: ____

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widowed

How did you hear about us? ❍ Friend/Family Member – Name: __________________________________ ❍ Yellow Pages ❍ Mail

❍ Clinic/Primary Care Physician – Name: ______________________________ ❍ Other: _______________

Primary Care Physician _________________________________ Phone (_______)____________________

Emergency Contact: ______________________________ Relationship: ____

Home Phone: (_____)_________________ Work Phone: (_____)______________ Cell Phone: (_____)_________________

Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Walsh Chiropractic Center, P.C., which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Printed Name: _____________________________ Signature: _______________________________ Date: ______________

Informed Consent

I hereby request and consent to the performance of a chiropractic evaluation, chiropractic adjustments, and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by Dr. Walsh and/or anyone working in this clinic authorized by Dr. Walsh.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and cerebrovascular accidents. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

Printed Name: _____________________________ Signature: _______________________________ Date: ______________

Consent to Treat Minors

I, __________________________, confirm that I am the parent/legal guardian of the above-mentioned patient give consent for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of WALSH FAMILY CHIROPRACTIC CENTER. ____ ____________________

Signature of Parent/Legal Guardian Date

Furthermore, I give consent to WALSH FAMILY CHIROPRACTIC CENTER to provide treatment to the above-mentioned minor during scheduled appointments with/without my presence in the facility. ___ (Please Initial)

Walsh Family Chiropractic Center | 1309 Jamestown Road, Suite 102 | Williamsburg, VA 23185| 757.220.4917 | 757.220.5884, fax

Financial Policy

Patient First Name: ____________________ **Last Name:** _____________________ **SSN** ____________________

Person Responsible for Bill

❍ self *(if "self," you do not have to complete the remainder of the information in this shaded box)*

❍ another individual

____ Date of Birth: _____/_____/_____
Last Name First Name Middle Name

Mailing Address: _________________________ City: ___________________________ State: ________ Zip: ________

Relationship to Patient: ____________________ Home Phone: (____)______________ SSN ____________________

Is this person a patient here? _______________ Employed By: ____________________ Work Phone: (____)________

Business Mailing Address: ______________________________ City: ______________ State: _______ Zip __________

Payment for Services will be made primarily by:

❍ Cash ❍ Check ❍ Credit Card ❍ Health Insurance ❍ Automobile Insurance ❍ Worker's Compensation

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. You will have 30 days upon receipt of a Statement of Account to pay in full without penalty. After 30 days you will begin to accrue interest at 14.4% APR.
3. After 90 days, delinquent accounts will be forwarded to a collection agency. At this time all costs associated with collections will become the patient's responsibility. In addition, if you, the patient, choose to acquire an attorney, you, the patient, will be responsible for all attorney fees.
4. This office may make payment plans/arrangements on an individual basis. Any such plan or arrangement will be discussed after your report of findings.
   a. If you enter into a payment agreement and discontinue care before the plan is completed, you will only be responsible for those services that have been provided to date. If the remaining balance is greater than that amount paid to date (due to the nature of the payment plan) the remaining account balance will be due. Should there be a credit, the credit will be refunded to you. If insurance is involved, refunds will be made after all insurance claims have been settled.
5. If you have questions concerning this or any other matter, please speak with the receptionist prior to seeing the doctor.

It is understood this is a highly specialized, unique and effective method of care. Knowing that 70% of the doctor's knowledge, expertise, time and technical equipment will be utilized in the first three weeks of patient's care; 20% in the second phase, and 10% in the final phase of care.

I have read and understand the Financial Policy.

________________________________ ____________
Patient's Signature Date

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Infant History – 2 Months to 2 Years

Patient Name:____ **Date:** ____________

Nutrition	Is your child still being breast fed? If No, for how long was he/she breast fed _________________________ If Yes, how much cow's milk does the mother consume each day? __________	☐ Yes ☐ No
	Is your child formula fed? If Yes, which formula or other milk source? ________________________	☐ Yes ☐ No
	Is your child eating solid food? If Yes: What foods does his/her diet contain? ______________________ What is your child's favorite food? _________________________	☐ Yes ☐ No
	Does your child have any feeding difficulties?	☐ Yes ☐ No
	Does your child have any digestive disturbances?	☐ Yes ☐ No
	Does your child have any food allergies?	☐ Yes ☐ No
	Does your child have any persistent or intermittent skin rashes?	☐ Yes ☐ No
	Is your child receiving any vitamin supplements?	☐ Yes ☐ No

Trauma	Has your child had any recent falls or trauma? If Yes, describe the trauma and the date it occurred _________________ ____	☐ Yes ☐ No
	Has your child ever fallen down stairs or fallen from a significant height?	☐ Yes ☐ No
	Has your child ever been in a motor vehicle collision or near-miss?	☐ Yes ☐ No
	Has your child ever had a bone fracture or joint dislocation?	☐ Yes ☐ No
	Has your child had any other trauma or injuries?	☐ Yes ☐ No
	Does your child ever bang his/her head repeatedly against a wall, bed, or other object?	☐ Yes ☐ No

Growth and Development	Can your child sit unsupported? If Yes, at what age did your child start to sit up? ________________months	☐ Yes ☐ No
	Is your child crawling yet? If Yes, at what age did your child start crawling? _______________months	☐ Yes ☐ No
	Is your child walking yet? If Yes, at what age did your child start to walk? ________________months	☐ Yes ☐ No
	Does your child often trip and fall?	☐ Yes ☐ No
	Do you have any other concerns about your child's growth and development? If Yes, what concerns? ____________________________________ ____	☐ Yes ☐ No

____

Guardian's Signature

Infant History – 2 Months to 2 Years

Health History	Has your child had colic?	☐ Yes ☐ No
	Has your child had any upper respiratory infections? If Yes, how often? ____	☐ Yes ☐ No
	Has your child had asthma?	☐ Yes ☐ No
	Does your child ever complain of back or neck pain?	☐ Yes ☐ No
	Does your child ever complain of pains in the arms or legs?	☐ Yes ☐ No
	Does your child ever complain of headaches?	☐ Yes ☐ No
	Has your child had any earaches? If Yes, at what age did the first earache occur? ______________________ If Yes, how frequently does your child have earaches? ________________	☐ Yes ☐ No
	If your child has earaches, in which ear do they usually occur? ☐ Right ☐ Left ☐ Both	
	Has your child had any other illnesses? If Yes, please list each illness and approximate date: _________________ ____ ____	☐ Yes ☐ No
	Is your child presently receiving any medications?	☐ Yes ☐ No
	Has your child ever been to a hospital or emergency room for evaluation or treatment?	☐ Yes ☐ No
	Has your child recently been vaccinated?	☐ Yes ☐ No
	Do you have any other concerns about your child's health? If Yes, what concerns: ____ ____	☐ Yes ☐ No

____

Guardian's Signature

Medications and Supplementations

Name of Medications and/or Supplements (to include prescription drugs, over the counter drugs, vitamins, etc)	How Much?	Frequency?

____ ____________________________________

Patient's Signature **Date**