

**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)

# 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

## School Age Child History – 6 Years and Older

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

<b>Reason for Today's Visit</b>	Complaint:	
	When did this occur?	
	Was onset:	<input type="checkbox"/> Sudden <input type="checkbox"/> Gradual
	Is problem:	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
	Has your child ever had this problem before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has your child previously been treated for this problem? If Yes, Doctor's name? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has your child previously had chiropractic care? If Yes, when? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>About Your Health (In the past year, have you had any of the following)</b>	Back or neck pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Pains in the legs or arms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Earaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Falls from a bicycle, skateboard, scooter, rollerblades, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you ever have a problem with bedwetting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever been in a motor vehicle accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever had any broken bones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever had any surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you at present taking any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any other health problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No

\_\_\_\_\_  
Guardian's Signature

## School Age Child History – 6 Years and Older

<b>About Your Lifestyle</b>	What grade are you in at school?	
	How do you carry your school books?	
	How heavy is your school book bag?	
	What sports do you play?	
	What hobbies do you have?	
	How many hours each day do you watch TV?	
	How many hours each day do you spend using a computer?	
	How often do you play video games?	
	On average, how many hours sleep do you get each night?	
	Are there any smokers in your family?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you feel stressed out?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have trouble reading the board in class?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you ever have blurred vision?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you wear glasses or contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you sometimes get headaches when you read?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>About Your Diet</b>	What do you usually eat for Breakfast?	
	What do you usually eat for Lunch?	
	What do you usually eat for Dinner?	
	What snacks do you have after school?	
	What is your favorite food?	
	How much water do you drink each day?	
	How many sodas or colas do you drink each day?	
	How often do you eat fast food items?	

\_\_\_\_\_  
Guardian's Signature

