Walsh Family Chiropractic Center | 1139 Professional Drive | Williamsburg, VA 23185| 757.220.4917 | 757.220.5884, fax

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)

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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.

_____ _____
Guardian's Signature Date

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Newborn History – Birth to 2 Months

Patient Name:_____ **Date:** _____

Reason for Today's Visit	Complaint:	
	When did this complaint begin?	
	What caused this complaint?	
	Has your child previously been treated for this problem? If Yes, by whom? _____ When _____	☐ Yes ☐ No

How many hours does your baby sleep between feeds?	During day _____	At Night _____

Is your baby…	Breast fed? If No, how long was baby breast fed _____ weeks/months	☐ Yes ☐ No
	Formula fed? Which formula or other milk source? _____	☐ Yes ☐ No

Does your baby…	Go to sleep easily?	☐ Yes ☐ No
	Have a preferred sleeping position?	☐ Yes ☐ No
	Cry if you change this sleeping position?	☐ Yes ☐ No
	Have any feeding difficulties?	☐ Yes ☐ No
	Have a one sided breast-feeding preference? If Yes, which breast? _____	☐ Yes ☐ No
	Frequently spit up after feeding?	☐ Yes ☐ No
	Cry a lot? How many hours each day? _____	☐ Yes ☐ No
	Pass a lot of intestinal gas?	☐ Yes ☐ No
	Have a preferred head position?	☐ Yes ☐ No
	Frequently arch his/her head and neck backwards?	☐ Yes ☐ No
	Cry or become irritable during a diaper change?	☐ Yes ☐ No

_____

Guardian's Signature

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Newborn History – Birth to 2 Months

Has your baby...	Ever had a fever?	☐ Yes ☐ No
	Had any falls?	☐ Yes ☐ No
	Been in a car accident or near miss?	☐ Yes ☐ No
	Had any other trauma?	☐ Yes ☐ No
	Been vaccinated?	☐ Yes ☐ No

Do you have any other concerns you wish to discuss?	

Guardian's Signature

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Medications

Name of Medications (to include prescription drugs & OTC drugs)	Condition	Dosage and Frequency (i.e. 5mg once a day, etc.)

Supplements

Medication Allergies

Medication Name	Reaction	Onset Date	Additional Comments

Guardian's Signature **Date**