

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.

Guardian's Signature

Date

Infant History – 3 Months to 2 Years

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 _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is your child formula fed? If Yes, which formula or other milk source? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is your child eating solid food? If Yes: What foods does his/her diet contain? _____ What is your child's favorite food? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your child have any feeding difficulties?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your child have any digestive disturbances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your child have any food allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your child have any persistent or intermittent skin rashes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is your child receiving any vitamin supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Guardian's Signature

Infant History – 3 Months to 2 Years

Growth and Development	Can your child sit unsupported? If Yes, at what age did your child start to sit up? _____ months	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is your child crawling yet? If Yes, at what age did your child start crawling? _____ months	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is your child walking yet? If Yes, at what age did your child start to walk? _____ months	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your child often trip and fall?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any other concerns about your child's growth and development? If Yes, what concerns? _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Health History	Has your child had colic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has your child had any upper respiratory infections? If Yes, how often? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has your child had asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your child ever complain of back or neck pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your child ever complain of pains in the arms or legs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your child ever complain of headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If your child has earaches, in which ear do they usually occur? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	
	Has your child had any other illnesses? If Yes, please list each illness and approximate date: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is your child presently receiving any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has your child ever been to a hospital or emergency room for evaluation or treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has your child recently been vaccinated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any other concerns about your child's health? If Yes, what concerns: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Guardian's Signature

