**OFFICE USE**

F/C: ☐ INS ☐ SP ☐ UC ☐ WC ☐ AA ☐ PI ☐ MC ☐ CAP PFC#: _____

Included: ☐ Insurance Card Copy ☐ Purple Letter ☐ Employer Claim Form ☐ Referral

# PEDIATRIC PATIENT INFORMATION

Thank you for choosing Pins Family Chiropractic Clinic. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information.

## 1 PATIENT INFORMATION

Date_____ Patient's Social Sec. #: _____-_____-_____ Date of Birth _____

First Name _____ Middle Initial _____ Last Name _____

Parent first name _____ Middle Initial _____ Last name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____

Email _____ Employer _____ Occupation _____

In case of emergency contact Name_____ Relationship _____

Home (_____) _____Work (_____) _____

Who were you referred by: _____

*Please complete the following section and present your Insurance Cards*

## 2 INSURANCE INFORMATION

| | PRIMARY INSURANCE | SECONDARY INSURANCE |
|---|---|---|
| Relation to Insured | ☐ Child ☐ Other | ☐ Child ☐ Other |
| Complete the following Insured information if *RELATION* is other than *SELF* | | |
| Insured's Name: | | |
| Insured's Birth Date: | | |
| Male or Female: | | |
| Complete the following Insured information if it differs from the Patient's | | |
| Insured's Address: | | |
| City, State, Zip: | | |
| Phone Number: | ( ) | ( ) |

## 3 ACCIDENT INFORMATION (If patient condition is due to an accident/injury)

| CLAIM FILING INFORMATION | |
|---|---|
| Accident type: | ☐ Auto Accident ☐ Personal Injury |
| Date of injury/accident: | |
| Insurance Carrier Name: | |
| Carrier address: | |
| City, State, Zip | |
| Adjuster's name: | |
| Adjuster's Phone Number: | ( ) |
| Claim Number: | |

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the chiropractic physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process Insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. Additionally, I authorize this office to release any and all of my medical records as deemed necessary. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

## 4 CHILD'S HEALTH HISTORY

Family Medical Physician (Name, Address, Phone) _____

Check any of the following conditions your child has suffered from in their lifetime:

**Birth**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Breech | ☐Yes ☐No | ADHD | ☐Yes ☐No | Digestive Problems | ☐Yes ☐No | Recurring Colds | ☐Yes ☐No |
| C-section | ☐Yes ☐No | Allergies | ☐Yes ☐No | Ear Infections | ☐Yes ☐No | Recurring Flues | ☐Yes ☐No |
| Forceps | ☐Yes ☐No | Appendicitis | ☐Yes ☐No | Growing Pains | ☐Yes ☐No | Recurring Strep/ Sore Throats | ☐Yes ☐No |
| Natural | ☐Yes ☐No | Asthma | ☐Yes ☐No | Headaches | ☐Yes ☐No | Seizures | ☐Yes ☐No |
| Suction Cup | ☐Yes ☐No | Bed Wetting | ☐Yes ☐No | Juvenile Arthritis | ☐Yes ☐No | Stomach Ulcers | ☐Yes ☐No |
| Other _____ | | Bowel Problems | ☐Yes ☐No | Measles | ☐Yes ☐No | Temper Tantrums | ☐Yes ☐No |
| | | Car Accident | ☐Yes ☐No | Mumps | ☐Yes ☐No | Tonsillitis | ☐Yes ☐No |
| | | Chicken Pox | ☐Yes ☐No | Pneumonia | ☐Yes ☐No | Vaccinations | ☐Yes ☐No |
| | | Colic | ☐Yes ☐No | | | Other _____ | |

Has your child ever been to a chiropractor?_____ If yes, when? _____ Reason? _____

Which contact sports does your child participate in? (circle) Soccer / Football / Gymnastics / Karate / Hockey / Basketball / Dance / Other _____

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child? ☐Yes ☐No (If yes, explain below under injuries/surgeries)

How many prescriptions of antibiotics has your child taken: During the past 6 months? _____ During his/her life? _____
How many other prescription medications has your child taken: During the past 6 months? _____ During his/her life? _____

| Injuries/Surgeries your child has had : | Description | Date |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |

Surgeries _____

## 5 MEDICATIONS (Prescription and over the counter), VITAMINS/HERBS/SUPPLEMENTS

_____

_____

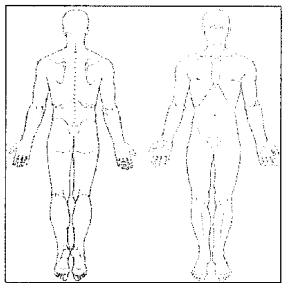
## 6 PATIENT CONDITION

Today's health complaint: _____

When did this symptom(s) appear?_____

Is this condition getting progressively worse? ☐Yes ☐No ☐Same

Mark an X on the picture where these symptoms are located (if applicable)



Type of pain (if applicable): ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How often is this symptom(s) present? ☐Occasional 0-25% ☐Intermediate 26-50% ☐Frequent 51-75% ☐Constant 76-100%

Does it interfere with ☐School ☐Sleep ☐Daily Routine ☐Recreation

Activities/movements that are difficult due to this symptom(s) ☐Eating ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down