Whom may we thank for referring you to our office? _____

BOEHMER CHIROPRACTIC FORM

PEDIATRIC HISTORY

Today's Date _____/_____/_____

Name_____ Date of Birth ____/____/____ Social Security # _____-_____-_____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____Fathers mobile: _____

Mother_____ DOB____/____/_____Father _____DOB____/____/_____

Pediatrician/Family MD _____City & State _____ Last Visit: ____/____/____

Purpose of last visit _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? ☐ No ☐ Yes: Who/When? _____

Who is responsible for this bill? ☐ Mother ☐ Father ☐ Other *(please explain)* _____

Insurance Company _____

PREGNANCY HISTORY:

Third Trimester Presentation: _____Vertex _____Breech _____Transverse _____Face/Brow

Type of Birth: _____Normal Vaginal _____Forceps _____Cesarean _____Suction Cap or Vacuum

Location: _____Home _____Hospital _____Birthing Center _____Other:_____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: _____Jaundice? (Yellow) _____Cyanosis? (Blue) _____Congenital Anomalies/Defects?

*If yes, please explain*_____

INFANT HISTORY:

Infant feeding: _____Breast _____Bottle If Bottle; which Formula? _____

Number of Hours sleep per night _____ Quality of Sleep: _____Good _____Fair _____Poor

List all **IMMUNIZATIONS** you child has had: _____

Has your child ever been treated at the emergency room? _____ If yes; please explain _____

Has your child ever been hospitalized? _____ If yes; please explain _____

Has your child ever had any Surgeries? _____ If yes; please explain _____

Is your child currently on any medication? _____ If yes; please list: _____

AT WHAT AGE DID THE CHILD:

Respond to sound_____ Follow an object with his/her eyes_____ Hold heel up_____

Sit Alone_____ Crawl_____ Stand_____ Walk alone_____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox_____ Mumps_____ Measles_____ Rubella_____

Whooping Cough_____ Other: _____

HAS YOUR CHILD EVER SUFFERED FROM:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to_____
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Allergies to_____
☐ Asthma	☐ Scoliosis	☐ Anemia	☐ Allergies to_____
☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Other: _____
☐ Colic	☐ Broken Bones	☐ Sleeping Problems	☐ Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other: _____

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain_____

_____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain_____

_____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: *Write "C" for child, "F" for family member:*

____ Heart Disease	____ Diabetes	____ Stroke
____ Cancer	____ High / Low blood pressure	____ Asthma
____ Gastrointestinal disease	____ Memory/mood disorder	____ Thyroid problem

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness _____Check-up _____Other: _____

_____Pain/Discomfort; explain_____

_____Injury; explain_____

If due to Pain/Discomfort/Injury, please fill out:

1. **Onset** of Problem: Date ____/____/_____ _____Unknown _____Gradual _____Sudden
2. **Ever had** this problem **before**? ☐ No ☐ Yes If yes when? _____
3. Any **bowel or bladder** problems since this problem began?: No Yes *(Describe)*:_____
4. Any **medication taken** for this problem? No Yes: _____
5. Have you seen any **other doctors** for this problem? No Yes: _____
6. How is this problem **NOW:** ☐Rapidly Improving ☐Improving Slowly ☐About the Same ☐Gradually Worsening ☐On & Off

I understand that I am directly and fully responsible to Boehmer Chiropractic for all chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are **the sole legal property** of this practice and that by law the doctor must retained these films for a period of no less than 7 years.

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter

X_____ _____Parent's or Legal

Guardian's Signature Date

Boehmer Chiropractic & Acupuncture
2216 Forum Blvd Ste 102
Columbia, MO 65202

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

☐ I, X_____(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

☐ I, _____(print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier. I do understand that PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Patient Signature: X_____ Date: _____

ASSIGNMENT OF BENEFITS

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

Assignment and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt my settlement award(s).

Patient Signature: X_____ Date: _____

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include, sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures. One of the rarest complications associated with Chiropractic cares (occurring at a rate between one instance per one million to one instance per five million) is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures enlisted by the doctor(s) in practice. This form was not signed until all my questions regarding treatment were answered to my complete satisfaction, and I conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor discussed with me that he/she deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

Patient Signature: X_____ Date: _____