

JangDhari Family Chiropractic

New Patient Intake Form for Child (0-17)

Name _____ Date _____

Date of Birth _____ Age _____

Home Phone _____ Cell Phone _____

Email Address _____

Address _____ City _____

State _____ Zip Code _____

Parent or Guardian's Name _____

Emergency Contact _____ Phone _____

How did you find out about our office? _____

Name of Primary Insurance Company (We only bill claims for Medicare Part B, Auto Accidents or Worker's Compensation)

Name of Secondary or Supplemental Insurance Company (if applicable)

Primary Care Physician Name _____ Phone _____

May we have your permission to update your primary care physician regarding your care at our office if necessary? Yes No

What brings you into our office today?

How long has this issue been going on?

Is this issue due to a work-related accident or an auto accident? Yes No

Have you had any major illnesses, falls or surgeries?

Have you been treated for any health conditions by a physician in the last year? Yes No

If yes, describe _____

What medications are you currently taking? _____

Authorization and Release

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with my primary care physician and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information, we encourage you to read the HIPAA notice that is available to you at the front desk before signing this consent.

The following person(s) have my permission to receive my personal health information _____

Patient's Signature _____

Date _____

Parent or Guardian's Signature Authorizing Care _____

Date _____

