

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI) _____ **Preferred Name:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home: _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____
Email: _____ **Gender:** M / F **Marital Status:** Married / Other / Single
Social Security #: _____ **Date of Birth:** _____
Student Status: Full Student / Part Student / Non-Student **Employed** **Employer:** _____
***Referred By:** _____

Ethnicity: Hispanic or Latino / Other **Preferred Language:** _____
Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White **Smoking Status:** Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Primary Care Physician:** _____
Home: _____ **Mobile:** _____ **Doctor's Phone:** _____
Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

Insurance Worker's Comp Self-Pay (Cash) Personal Injury/Auto Other (please explain): _____

PRIMARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ **Gender:** M / F
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Date of Birth:** _____

SECONDARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ **Gender:** M / F
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Date of Birth:** _____

Who is responsible for payment? Self / Other - (*Relationship*) _____

Other than Self:

Full Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____

PEDIATRIC QUESTIONNAIRE

Name: (Last, First MI) _____

Today's Date: _____



PEDIATRIC REVIEW OF SYSTEMS

Pediatric:

- ADHD
- Allergies/Asthma
- Autism
- Back/Neck Pain
- Bed Wetting
- Behavioral issues
- Chronic Earaches
- Colic
- Constipation
- Growing Pains
- Nightmares
- Reflux
- None in this Category

Childhood Diseases:

- Chicken Pox: Age _____
- Measles: Age _____
- Meningitis: Age _____
- Mumps: Age _____
- Rubella: Age _____
- Tuberculosis: Age _____
- Whooping Cough: Age _____
- Other: _____ Age _____
- None in this Category

Has your child been vaccinated?

- No Yes

(Any Adverse Reactions? - Describe:) _____



INFANTS AND NEWBORNS

Prenatal History:

Location of Birth: Home Birthing Center Hospital

Birth Weight: _____ Birth Length: _____ Full Term? No Yes (Describe) _____

Complications during pregnancy? No Yes (Describe) _____

Medications during pregnancy or delivery? No Yes (List) _____

Cigarette / Alcohol / Drugs during pregnancy? No Yes (List) _____

Birth Interventions? No Yes Forceps Vacuum Caesarian Other: _____

Complications during delivery? No Yes (Describe) _____

Feeding History:

Breast fed? No Yes (How Long?) _____ Formula fed? No Yes (How Long?) _____ (Type?) _____

Introduced to cereal at _____ months old. Solids at _____ months old. Cow's milk at _____ months old.

Food / Juice allergies or intolerances? No Yes (Describe) _____

Developmental History:

Sleep (Hours per Night?) _____ Problems Sleeping? (Describe) _____

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize: _____ (Doctor's Name) and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to: _____ (Minor Patient's Name)

Printed Name of Parent or Guardian

Signature of Parent or Guardian

Date

Witness

Date

Patient No: _____

CONSENTS

CONSENT TO BILL/COLLECT INSURANCE: I CONSENT, IF I AM USING A THIRD PARTY FOR PAYMENT OF MY SERVICES (HEALTH INSURANCE, AUTO ACCIDENT INSURANCE, WORKER'S COMPENSATION INSURANCE, PARENT/GUARDIAN, ETC), TO ALLOW SOUTH OKC CHIROPRACTIC CLINIC (DR. TYLER PERTREE) TO SUBMIT ALL NECESSARY INFORMATION NEEDED TO RECEIVE PAYMENT FOR THE SERVICES I RECEIVED TO THESE THIRD PARTIES. I FURTHER CONSENT TO ACCEPT ASSIGNMENT OF PAYMENTS FROM MY INSURANCE COMPANY TO BE PAID DIRECTLY TO THE CLINIC OR DOCTOR.

PATIENT/GUARDIAN NAME

PATIENT/GUARDIAN SIGNATURE

DATE

CONSENT TO EXAMINATION AND TREATMENT: I GIVE THE DOCTORS AND STAFF OF SOUTH OKC CHIROPRACTIC CLINIC PERMISSION TO PERFORM ALL EXAMINATIONS, X-RAYS, AND TREATMENT DEEMED NECESSARY BY THE DOCTOR. I UNDERSTAND THAT SOME OF THESE PROCEDURES MAY BE PERFORMED BY EITHER THE STAFF OR THE DOCTOR.

PATIENT/GUARDIAN NAME

PATIENT/GUARDIAN SIGNATURE

DATE

CONSENT TO RETRIEVE MEDICAL RECORDS: I GIVE THE DOCTORS AND STAFF OF SOUTH OKC CHIROPRACTIC CLINIC PERMISSION TO OBTAIN ANY AND ALL MEDICAL RECORDS FROM OTHER PROVIDERS, OFFICES OR HOSPITALS WHICH MAY ASSIST WITH MY CARE.

PATIENT/GUARDIAN NAME

PATIENT/GUARDIAN SIGNATURE

DATE

HIPPA: A COPY OF THE FULL HEALTH INFORMATION PRIVACY POLICY FOR OUR CLINIC CAN BE REQUESTED AT OUR FRONT DESK. IN BRIEF, IT STATES THAT WE WILL NOT GIVE ANY INFORMATION ABOUT YOU EXCEPT AS CONSENTED TO ABOVE. THE ONLY PEOPLE WE GIVE INFORMATION TO IS PARENTS/GUARDIANS IF YOU ARE A MINOR OR WHOMEVER IS RESPONSIBLE FOR YOUR BILL (I.E. INSURANCE COMPANY, THIRD PARTY, OR ATTORNEY IF YOU HAVE ONE).

PATIENT/GUARDIAN NAME

PATIENT/GUARDIAN SIGNATURE

DATE

CLINICAL SUMMARY REPORT (CCR): I UNDERSTAND THAT A CLINICAL SUMMARY REPORT IS CREATED AFTER EACH VISIT FOR THE PURPOSE OF EHR AND IS AVAILABLE FOR MY REVIEW. AT THIS TIME, I AM ASKING SOUTH OKC CHIROPRACTIC CLINIC TO SAVE THESE ELECTRONICALLY FOR ME AND NOT PRINT THEM OUT AFTER EACH VISIT. I UNDERSTAND THAT, UPON REQUEST, THESE REPORTS ARE AVAILABLE TO BE PRINTED OR EMAILED TO ME FOR REVIEW.

PATIENT/GUARDIAN NAME

PATIENT/GUARDIAN SIGNATURE

DATE

PREGNANCY WAIVER (WOMEN ONLY): BY MY SIGNATURE BELOW, I AM STATING THAT TO THE BEST OF MY KNOWLEDGE, I AM NOT PREGNANT NOR IS PREGNANCY SUSPECTED AT THIS TIME.

PATIENT/GUARDIAN NAME

PATIENT/GUARDIAN SIGNATURE

DATE