GRAY CHIROPRACTIC HEALTH CLINIC

PEDIATRIC PATIENT REGISTRATION

CONTACT INFORMATION:

Child's Name: _____ Child's Social Security: _____-_____-_____
last first middle

Mother's Name: _____ Father's Name: _____

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

Home Phone: _____ Mother's Work/Cell Phone: _____ Father's Work/Cell Phone: _____

Fathers Email: _____ Mothers Email: _____

Obstetrician/Midwife: _____
Name Location and Phone #

Pediatrician/Family MD: _____
Name Location and Phone # Date of Last Visit

INSURANCE INFORMATION:

Primary

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co: _____

ID Number: _____

Group #: _____

Secondary (if applicable)

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co: _____

ID Number: _____

Group #: _____

ASSIGNMENT & RELEASE – PLEASE NOTE: YOU MUST SIGN BELOW EVEN IF YOU DO NOT HAVE INSURANCE

I, the undersigned certify that my dependant has insurance coverage with _____ and assign directly to Dr. Jennifer Waldroup Gray DC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ ____/____/____
Responsible Party Signature Relationship to Patient Date

AUTHORIZATION FOR CARE OF A MINOR

Chiropractic examination and therapeutic procedures including but not limited to spinal adjustments, ultrasound, heat/ ice application, electrotherapy, and manual muscle therapy are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

I HEREBY AUTHORIZE GRAY CHIROPRACTIC HEALTH CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY FOR MY CHILD/WARD.

_____ _____ ____/____/____
PARENT / GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT DATE

GRAY CHIROPRACTIC HEALTH CLINIC

PEDIATRIC PATIENT CASE HISTORY

Patient's Name: _____ Date of Birth: _____/_____/_____ Gender: M F

Reason for this visit: _____

Age: _____ Birth Weight: _____ Current Weight: _____ Birth Length: _____ Current Length: _____ # of Siblings: _____

Childs Congenital Anomalies/Defects: _____

Family History of Congenital Anomalies/Defects: _____

Type of Birth (circle all that apply): Normal Vaginal Forceps Breech Cesarean

Birthing Location: Home Birth Birthing Center: _____ Hospital: _____

Pregnancy History / Problems During Pregnancy: _____

_____

Delivery & Birth History / Problems During Labor & Delivery: _____

_____

APGAR Scores: ____ ____ Was there presence at birth of: ____ Jaundice (yellow) ____ Cyanosis (blue)

Infant Feeding: Breast: ____ # of Months: _____ Bottle: ____ # of Months: _____

Formula: _____ # of Months: _____ Brand(s): _____

Number Of Hours of Sleep Per Night: _____ Quality of Sleep (circle): Good Fair Poor

Immunization History: _____

Developmental History - At what age did the child:

___ mo/yrs Respond to sound
___ mo/yrs Follow an object with his/her eyes
___ mo/yrs Hold head up
___ mo/yrs Crawl
___ mo/yrs Sit unaided
___ mo/yrs Stand unaided
___ mo/yrs Walk unaided

Childhood Diseases (check all that apply):

___ Chicken Pox ___ Mumps
___ Measles ___ Rubella
___ Rubeola ___ Whooping Cough
Other:_____

Has this child ever suffered from (check all that apply):

__ Dizziness	__ Bed wetting	__ Tuberculosis	__Blood Disorders	__ Chronic earaches
__ Diabetes	__ Digestive Disorders	__ Headaches	__ Heart trouble	__ "Growing pains"
__Arthritis	__ Fainting	__ Hyperactivity	__ Hypertension	__ Allergies
__ Neuritis	__ Neck problems	__ Convulsions	__ Asthma	__ Constipation
__ Anemia	__ Joint problems	__ Rheumatic Fever	__ Sinus trouble	__ Diarrhea
__ Poor appetite	__ Backaches	__ Arm problems	__ Walking problems	__ Behavioral problems
__ Paralysis	__ Broken bones	__Leg problems	__ Muscle jerking	
__ Colds/Flu	__ Stomach Aches	__Ruptures/Hernias	Other:_____	

Present History & Allergies: _____

_____

Surgeries: _____ Accidents:_____ Medications:_____

Family History: _____

Gray Chiropractic Health Clinic LLC
Dr. Charlie Gray & Dr. Jennifer Waldroup-Gray

Consent for Purposes of Treatment, Payment & Healthcare Operations (8/09)

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to Gray Chiropractic Health Clinic LLC.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.
I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 360 E. Intl. Airport Rd. #4, Anchorage, AK 99518. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority