ALLEN CHIROPRACTIC CARE

43 N 300 W Ste B
Washington, Ut 84780
(435) 986-1021

Name: _____ Date: _____
Address: _____ State: _____ Zip: _____
H. Phone: _____ C. Phone: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____
Referred by: _____
Occupation: _____ Employer: _____
Marital Status S M D W Spouse Name_____
Insurance Company_____ Please give card to the front desk so it can be copied.
Have you ever received Chiropractic Care? Yes No

Insurance Patients:
Allen Chiropractic Care offers insurance billing as a service to our patients. We are providers for a number of insurance companies. Each insurance company is different and offers their members a variety of plans. All plans are diverse with different benefits for each plan. Your insurance card is not a guarantee of benefits or payment, and some chiropractic services may be denied payment by your Insurance Company. All agreements made are between you (the beneficiary) and the Insurance Company. Allen Chiropractic Care will do everything in its power to ensure you receive your maximum chiropractic benefits from your Insurance company, but please understand that we are a third party in your insurance agreement, and as such, are limited.

Cash Patients:
Allen Chiropractic Care offers low rates to our Cash patients. The first visit (consultation, exam, adjustment and report of findings) is $55 and each visit thereafter is only $55. We are providers for a Discount Medical Plan. If you are able to join this Discount Medical Plan it allows us to reduce our fee to $35. We are able to offer these low rates because you are a member of that Discount Medical Plan.
If at any time, you need to defer payment and wish to be billed for the visit, a $5 billing fee will be added to the full balance for each bill sent (bills will be sent out once a month).

Past Health History:
A. Previous major illnesses you've had in your life**:** _____
B. Previous accidents, injury or trauma**:** _____
Have you ever broken any bones? Which? _____
C. Allergies: _____
D. Medications**:** _____
_____
E. Vitamins or supplement**:** _____
F. Surgeries**:** _____

Family Health History:
Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side:	☐	☐	☐	☐	☐
Mother's side:	☐	☐	☐	☐	☐

Family History: Health conditions, age of death and cause of death.
Father: _____
Mother: _____
Brother/s & Sister/s: _____

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Prenatal History

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Stepchild ☐ Adopted

Was labor induced: Y / N _____
Complications during pregnancy: Y / N _____
Ultrasounds during pregnancy: Y / N Number: _____
Medications during pregnancy/delivery: Y / N List: _____
Cigarette, Drug, or Alcohol use during pregnancy: Y / N _____
Birth intervention: ☐ Forceps ☐ Vacuum ☐ Caesarian Reason _____
Breach/ cephalic: Y / N _____
Complications during delivery: Y / N _____
Genetic disorders or disabilities: Y / N _____
Birth weight_____ Birth length_____

Feeding history

Breast Fed: Y / N How long _____ Formula fed: Y / N How long _____ Type: _____
Introduced to solids at _____ months. Cow's milk at _____ months
Food / juice allergies or intolerances Y / N List: _____

Developmental History

Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____
At what age was your child able to: Crawl _____ Sit alone _____ Stand alone _____ Walk alone _____ Say words _____

Growth and Development/ Childhood:

Ear infections/ Colic/ Asthma Y / N _____
Drugs, prescription, OTC, recreational Y / N _____
Surgery Y / N _____
Hospitalizations Y / N _____
Sports or other physical activities Y / N _____
Injuries during sports Y / N _____
Auto accidents Y / N _____
Did they have other traumas Y / N _____

Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N _____
Other traumas not described above Y / N Type & Date: _____

Childhood Diseases

☐ Chicken Pox - Age _____ ☐ Mumps - Age _____ ☐ Rubella - Age _____ ☐ Whooping cough - Age _____
☐ Measles - Age _____ ☐ Meningitis - Age _____ ☐ Tuberculosis - Age _____ ☐ Other - Age _____

Vaccination History:

☐ HBV / Hep B (Hepatitis B) – Age _____
☐ DTP or DTaP (Diphtheria, Tetanus, Pertussis) – Age _____
☐ HbCV / Hib (H. influenzae type b conjugate) – Age _____
☐ OPV (Oral Polio Vaccine) or ☐ IPV (Inactivated Poliovirus) – Age _____
☐ MMR (Measles, Mumps, Rubella) – Age _____
☐ Varicella (Chicken Pox) – Age _____
☐ PCV (Pneumoccocal) – Age _____

Adverse Reactions to Any Vaccine? Y / N List: _____

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Symptoms: Please check any current or past problems your child has on the list below:

__Dizziness	__Itchy Eyes	__Hyperactivity	__Hernias
__ADHD	__Rashes	__Poor Memory	__Neck Pain
__Backaches	__Unusual Moles	__Insomnia	__Arm/Elbow Pain
__Heart Condition	__Digestive	__Nightmares	__Leg/Hip Pain
__Chronic Earaches	__Sinus Trouble	__Bed Wetting	__Knee/Foot Pain
__Diabetes	__Cough/Wheeze	__Pain Urinating	__Growing pains
__Fever/Chills	__Chest Pain	__Convulsions	__Joint Pain
__Frequent Colds	__Constipation	__Paralysis	__Scoliosis
__Headaches	__Anemia	__Muscle Pain	__Blood disorders
__Asthma	__Rheumatic Fever	__Broken bones	__Stomach Aches
__Allergies	__Diarrhea	__Sprains/Strains	__Fainting
__Runny Nose	__Poor Appetite		

Health History:
Name of Pediatrician: _____ Date of last visit _____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on (or on the patient named below, or for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctor of chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as a back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustment and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels is in my best interest, based upon the facts then known.

Under HIPPA guidelines, I consent to the procedures of this office including my name being visible on the daily sign in sheet.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient/Guardian Signature (if minor) *Date*

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Arbitration Agreement

Arbitration is a way to decide health care complaints without going to court. By signing this agreement, my doctor(s) and I are choosing arbitration rather than going to court as a way of resolving any future claim about my chiropractic care. This agreement only applies to the care that I receive in this office from the undersigned chiropractor, or any office assistants or, employed assigned to my care by my chiropractor immediately following the execution of this form during the time when this form is in effect.

This agreement does not apply to disagreements over the fees charged. State law gives me a choice of two ways to decide claims; either a trial by a judge or jury, or arbitration. I have a right to a lawyer for a trial or arbitration. If I select arbitration, my case will be decided by a panel of three people instead of a judge or jury. The arbitration panel will contain a lawyer, a member of the public, and a Doctor of Chiropractic. My doctor and I will take part in choosing the panel members who will decide the case. If the parties involved in the case cannot agree on the panel members, the American Arbitration Association and my doctor's state or national association representative may appoint the panel members. State laws and rules of the American Arbitration Association will apply to all arbitration hearings, and may vary from state to state. All parties are delegated to investigate on their own and/or seek counsel. I am choosing arbitration of my own free will. This agreement applies to me, my heirs, and my legal representatives.

If I want to change my mind and cancel this agreement, I must notify my doctor in writing within 60 days after I sign. After 60 days, I cannot change my decision unless mutually agreed upon by all parties. In most cases, a decision by an arbitration panel is final and cannot be appealed.

This agreement to arbitrate is not a prerequisite to health care or treatment and may be revoked within 60 days after execution by notification in writing to:

_____ _____

Signature of Chiropractic Representative *Patient Signature* *Date*

I CERTIFY THAT I AM THE PARENT OF THE MINOR CHILD, THE GUARDIAN, OR OTHER LEGAL REPRESENTATIVE OF THE PATIENT INVOLVED.

_____

Parent/Guardian/Legal Representative Date