Perreault Chiropractic

Dr. Roger E. Perreault, DC *Dr. Nicole R. Perreault, DC, L.Ac*
Phone: (320) 358-3441 / Fax: (320) 358-3624
263 West 4th St, P.O. Box 86 Rush City, Minnesota 55069
Family Chiropractic **Acupuncture** **Automobile Injury**

INFANT HISTORY
(2 MONTHS TO 2 YEARS)

Today's Date:_________________________

PATIENT INFORMATION

Child's Name: _________________________________ Gender: ________________
Date of Birth: ___________________________________

The following questions are designed to help the doctor provide a detailed evaluation of your child.

TRAUMA	YES	NO	EXPLAIN
Has your child had any recent falls/trauma?	☐	☐	______________________
Has your child every fallen down stairs or fallen from any height?	☐	☐	______________________
Has your child ever been in a motor vehicle accident or near miss?	☐	☐	______________________
Has your child ever had a bone fracture or joint dislocation?	☐	☐	______________________
Has your child had any other trauma or injuries?	☐	☐	______________________
Does your child ever bang their head against a wall, bed, or other object?	☐	☐	______________________

HEALTH HISTORY			
Has your child had colic?	☐	☐	______________________
Has your child had any upper respiratory infections?	☐	☐	______________________
Has your child had asthma?	☐	☐	______________________
Does your child ever complain of neck or back pain?	☐	☐	______________________
Does your child ever complain of arm or leg pain?	☐	☐	______________________
Does your child ever complain of headaches?	☐	☐	______________________
Has your child had earaches? If yes what age did they first occur?	☐	☐	______________________
Do your child's earaches tend to occur in the same ear? Is it right, left or both? _______	☐	☐	______________________
Has your child had any other illnesses? Date?	☐	☐	______________________
Is your child presently receiving any medications?	☐	☐	______________________

Has your child ever been hospitalized or evaluated in an emergency room?	☐	☐	________________________
Has your child recently been vaccinated?	☐	☐	________________________
Do you have any other concerns?	☐	☐	________________________

PREGNANCY HISTORY

How many children do you have? __________
What was the term of your pregnancy? _______ weeks.

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING? EXPLAIN

	YES	NO	
Falls	☐	☐	____
Motor Vehicle Accident(s)	☐	☐	____
Near-Miss MVA	☐	☐	____
High Blood Pressure	☐	☐	____
Diabetes	☐	☐	____
Anemia	☐	☐	____
Morning Sickness	☐	☐	____
Indigestion	☐	☐	____
Seizures	☐	☐	____
Swollen Ankles	☐	☐	____
Thyroid Problems	☐	☐	____
Heart Problems	☐	☐	____
Back Pain	☐	☐	____
Abnormal Bleeding	☐	☐	____
Were you hospitalized	☐	☐	____
Any other illness	☐	☐	____

Any other information you wish to add about your pregnancy;
____
____
____
____
____

BIRTH HISTORY

LABOR AND DELIVERY

How long was the labor from the first regular contractions to birth? ______ hours.
How long was the 2nd stage (the pushing phase) of the labor? ________ hours.

	YES	NO	
Hospital Birth	◻	◻	________________________________
Home Birth	◻	◻	________________________________
Midwife assisted	◻	◻	________________________________
Vaginal Delivery	◻	◻	________________________________
Planned C-Section	◻	◻	________________________________
Emergency C-Section	◻	◻	________________________________
Induced birth (Pitocin)	◻	◻	________________________________
Forceps delivery	◻	◻	________________________________
Vacuum extraction	◻	◻	________________________________
Head presentation	◻	◻	________________________________
Face presentation	◻	◻	________________________________
Breech presentation	◻	◻	________________________________

FAMILY INFORMATION

Mother's Name: ____
Address: _____________________________________
City ___________________ State _____ Zip ___________
Home Phone: _________________________ Cell:________________________
Father's Name: ____
Address: _____________________________________
City ___________________ State _____ Zip ___________
Home Phone: _________________________ Cell:________________________

INSURANCE INFORMATION

Primary Insurance: ________________________________
Name of Insured: __________________________
Date of birth of insured: _________________
Secondary Insurance: _____________________________
Name of Insured: ___________________________
Date of birth of insured: _________________

CONSENT TO TREAT: Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named above as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care regardless of what my insurance company covers. I hereby authorize Perreault Chiropractic to seek payment and authorize/assign payment directly to them from my insurance company.

PARENT GUARDIAN SIGNATURE:

____

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Consent to the Use and Disclosure of Health information for Treatment, payment, or Healthcare operations.

I understand that as part of my healthcare, Perreault Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses treatment, and any future plans for care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a “Notice of Privacy Practices” that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Perreault Chiropractic reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I’ve provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Perreault Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Perreault Chiropractic has already taken action in reliance thereon.

Authorization and Assignment of Benefits

I hereby authorize Perreault Chiropractic to release to my insurance company information necessary for them to process my claims for care. I also assign insurance benefits to Perreault Chiropractic as may be allowed by my insurance company. I further understand that I am fully responsible for all the charges incurred at Perreault Chiropractic regardless of my insurance coverage. Please note: We will do all we can to insure your care is covered by your insurance carrier. However, benefits quoted to us over the phone are not a guarantee of payment but a general outline of your coverage. If a problem arises we will appraise you as soon as possible and will expect you to call your insurance carrier to clear up any problems. Please keep in mind your contract is between you and your insurance carrier. We do not have any legal rights to your insurance contract – you do. Please be aware that many insurance carriers can take up to 3 months or more to process a claim.

Signature: ____ Date: _______________