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

PRE-SCHOOL CHILD HISTORY
(3 YEARS TO 5 YEARS)

Today's Date: _____
Child's Name: _____ Gender: _____
Date of Birth: _____
Reason for today's visit: _____
_____

Please answer the following YES NO
COMMENTS

Does your child complain of pain or discomfort?
If yes when did it start? 0 0 _____
Was onset Sudden 0 or Gradual 0 Is problem Constant 0 or Intermittent 0
Has your child ever had this problem before? 0 0 _____
Has your child been treated for this problem previously?
By whom? 0 0 _____
Has your child had chiropractic care before? 0 0 _____
Previous chiropractor _____

HEALTH HISTORY

Does your child ever complain of back or neck pain? 0 0 _____
Does your child ever complain of leg or arm pain? 0 0 _____
Does your child ever complain of headaches? 0 0 _____
Has your child had asthma? 0 0 _____
Does your child have allergies? 0 0 _____
Are there any smokers in the home? 0 0 _____
Has your child had earaches?
At what age did they first occur? 0 0 _____
How frequently do the earaches occur? _____
Are they in Right 0, Left 0, or Both 0
Is your child presently taking any medication? 0 0 _____
Please list any other illness which has been a concern for your child;
_____
_____
Has your child ever had surgery? If so what type? 0 0
_____

TRAUMA

Has your child had any recent falls or trauma? When? 0 0 _____
Has your child ever fallen from a significant height? 0 0 _____
Has your child ever had a bone fracture? 0 0 _____
Does your child every bang his/her head repeatedly? 0 0 _____

NUTRITION

Do you have any concerns about your child's nutrition?	0	0	_____
Does your child have food allergies?	0	0	_____
Does your child have a persistent or recurring rash?	0	0	_____
Does your child take vitamins?	0	0	_____
Does your child eliminate stools every day?	0	0	_____

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: _____