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

SCHOOL-AGE CHILD HISTORY
(6 years and older)

Name_____ Date_____
Reason for today's visit _____
When did this problem first occur? _____

	Comments	YES	NO
Have you ever had this problem before?	_____	0	0
Have you been treated for this problem before?	_____	0	0
	Doctor's name_____		
Have you previously been to a chiropractor?	_____	0	0

ABOUT YOUR LIFESTYLE

The following questions are designed to help the doctor provide the best possible spinal care for your child.

What grade are you in at school:_____
How do you carry your school books?: _____
How heavy is your school book bag?_____
What sports do you play? _____
What hobbies do you have? _____
How many hours each day do you watch TV/play video games/use the computer? _____
On average how many hours of sleep do you get each night? _____

	Comments	YES	NO
Are there any smokers in your family?	_____	0	0
Do you feel stressed out?	_____	0	0
Do you have trouble reading the board in class?	_____	0	0
Do you ever have blurred vision?	_____	0	0
Do you wear glasses or contact lenses?	_____	0	0

ABOUT YOUR HEALTH

In the past have you had any of the following:

	Comments	YES	NO
Back or neck pain?	_____	0	0
Pains in the legs or arms?	_____	0	0
Headaches?	_____	0	0
Asthma?	_____	0	0

Allergies? _____	0	0
Earaches?_____	0	0
Falls from a bike, skateboard, scooter, etc? _____	0	0
Do you ever have a problem with bedwetting? _____	0	0
Have you ever been in a motor vehicle accident? _____	0	0
Have you ever had any broken bones? _____	0	0
Have you ever had any surgeries? _____	0	0
Are you presently taking any medications? _____	0	0
Do you have any other health problems? _____	0	0

FAMILY INFORMATION

Mother's Name: _____
Address: _____ City _____ State ____ Zip _____
Home Phone: _____ Cell: _____ Work: _____
Father's Name: _____
Address (If different than Mother's) _____City _____ State____ Zip____
Home Phone: _____ Cell: _____ Work:_____

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: _____