

*Dr. James Jessen - Dr. Jon Stowe - Dr. John Jordan*

**PEDIATRIC HISTORY FORM**

**Child’s name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ **Gender:** ⬜ Male ⬜ Female

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⬜ Cell ⬜ Home

**City/State/Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Would you like to receive appointment reminders via text message?** ⬜ Yes ⬜No

**Would you like to receive billing statements via E-pay? It is an electronic option sent to you via text/email?**  ⬜ Yes ⬜ No

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY**

**Check any of the following conditions that apply:**

⬜ Ear Infections ⬜ Scoliosis ⬜ Chronic cold ⬜ Headache

⬜ Allergies ⬜ Digestive Issues ⬜ ADHD/ADD ⬜ Recurring Fever

⬜ Colic ⬜ Growing/back pain ⬜ Bedwetting ⬜ Temper tantrums

⬜ Reflux ⬜ Tonsillitis ⬜ Asthma ⬜ Eczema/Psoriasis

⬜ Autism/Spectrum ⬜ Developmental Delay ⬜ Constipation ⬜ Diarrhea

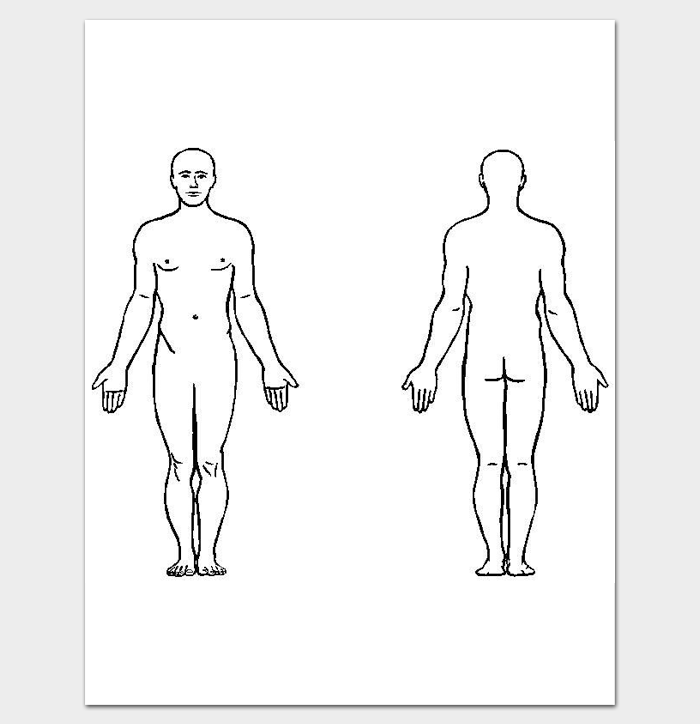
⬜ Seizures ⬜ Sleep Issues ⬜ Nursing/Latch issues

**Describe the purpose of this visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When and how did this health challenge begin:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Since the problem began, is it:** ⬜ Getting better ⬜ Getting worse ⬜ About the same

**What is the pattern of this problem?** ⬜ Constant ⬜ Intermittent ⬜ Occasional ⬜Cyclic

**What have you tried to improve this condition?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⇦ **Using this diagram, please indicate the area of pain or discomfort.**

**To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my child’s doctor if my minor child ever has a change in health.**

**Name of Parent/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship to child:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT FOR CHIROPRACTIC CARE:**

I hereby consent to give the doctor(s) of chiropractic and anyone working in the Jessen Family Chiropractic office authorized by the chiropractor(s) permission and authority to care for my child (the minor listed here): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for whom I am legally responsible. Chiropractic tests, diagnosis, analysis and adjustments are very safe and beneficial and rarely carry any risk. In rare cases, underlying physical defects, deformities or pathologies may make your child prone to injury. It is the responsibility of the child’s parent/guardian to make it known, or to learn through health care procedures if your child is suffering from latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractor(s). The doctor(s) of chiropractic will not give any treatment or care if he or she is aware that such care should not be used for a particular condition or circumstance. Your child’s doctor(s) of chiropractic are licensed primary care provider(s) and are available to work with all other types of providers.

I am authorizing my child’s doctor(s) to proceed with any treatment that they deem necessary. I have the right to a second opinion and to secure other opinions about my child’s circumstances and health care as I see fit. Furthermore, any questions that I have regarding chiropractic care will be explained upon my request.

**Parent/Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT AND RELEASE:**

I certify that I (or my dependent) have insurance coverage with the carrier I provided and AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO JESSEN FAMILY CHIROPRACTIC ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Should my insurance carrier not remit payment within 60 days I will be expected to pay my account balance. The contract is between my insurance carrier and I. I understand I may have to follow up with the insurance carrier regarding unpaid claims. I also understand that I am responsible for my copay, deductible and coinsurance at the time of service. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions. This authorization is in effect until I choose to revoke it.

**Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**PATIENT FINANCIAL RESPONSIBILITY:**

We are pleased to assist you with your chiropractic insurance. If you have medical insurance with chiropractic coverage, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met, or plan benefits have changed. Under your health plan, you are financially responsible for copayments, co-insurance and deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may choose to receive maintenance care once maximum benefit from treatment has been reached. If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

By signing below, I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

**Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**HIPAA NOTICE PROVIDED:**

**Initials:** \_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_