Pediatric History Form

Today's Date: ____________________ HR#: ______________________

PATIENT DEMOGRAPHICS

Child's Name: ____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

Birth Height: ____________ Birth Weight: ____________ Current Height: ____________ Current Weight: ____________

Address: ____ City: ______________________________ State: ____ Zip: _________

Mother's Name: ____ Birthdate: _____-_____-_____

Mother's Phone: Home __________________________ Work _________________________ Mobile _________________________

Father's Name: ____ Birthdate: _____-_____-_____

Father's Phone: Home __________________________ Work _________________________ Mobile _________________________

Pediatrician/Family MD: ____ City/State: _______________________________

Last Visit Date: _____-_____-_____ Reason for visit: ____

Who is responsible for this bill? ____

○ Father's Social Security #: _____-_____-_____ ○ Mother's Social Security #: _____-_____-_____

○ Father's Driver's License #: _____________________ ○ Mother's Driver's License #: _____________________

○ Other *(please explain)*: ____

CHILD'S CURRENT PROBLEM

Purpose of this visit: ○ Wellness Check-up ○ Injury or Accident ○ Other

Please explain: ____

If your child is experiencing **pain/discomfort, please identify where and for how long:**

____

____

1. When did the problem first begin? Date: _____-_____-_____ ○ Unknown ○ Gradual ○ Sudden
2. Has this problem occurred before? ○ No ○ Yes If yes, when? ____
3. Any bowel or bladder problems since this problem began? ○ No ○ Yes **If yes,** describe: _____________________________

   ____
4. Have you seen any other doctors for this problem? ○ No ○ Yes **If yes**, whom? _______________________________________
5. How long ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatment? ____
7. How is this problem NOW?

   ○ Rapidly Improving ○ Improving Slowly ○ About the Same ○ Gradually Worsening ○ On and Off
8. Please list any medication(s) taken for this problem: ____

9. Has your child ever sustained an injury playing organized sports? O No O Yes **If yes,** please explain:

____

____

10. Has your child ever sustained an injury in an auto accident? O No O Yes **If yes,** please explain:

____

____

HAS YOUR CHILD EVER SUFFERED FROM - *Check all that apply*

O Headaches	O Orthopedic Problems	O Digestive Disorders	O Behavioral Problems
O Dizziness	O Neck Problems	O Poor Appetite	O ADD/ADHD
O Fainting	O Arm Problems	O Stomach Aches	O Ruptures/Hernia
O Seizures/Convulsions	O Leg Problems	O Reflux	O Muscle Pain
O Heart Trouble	O Joint Problems	O Constipation	O Growing Pains
O Chronic Earaches	O Backaches	O Diarrhea	O Asthma
O Sinus Trouble	O Poor Posture	O Hypertension	O Walking Trouble
O Scoliosis	O Anemia	O Colds/Flu	O Sleeping Problems
O Bed Wetting	O Colic	O Broken Bones	O Fall off swing
O Fall in baby walker	O Fall from bed or couch	O Fall from crib	O Fall down stairs
O Fall off bicycle	O Fall from high chair	O Fall off slide	
O Fall from changing table	O Fall off monkey bars	O Fall off skateboard/skates	

O Allergies to ____

O Other: ____

I understand that I am directly and fully responsible to [Insert Practice Name] for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____________________________________ ______ - ______ - ______

Parent or Legal Guardian's Signature **Date Completed**

_____________________________________ ______ - ______ - ______

Doctor's Signature **Date Form Reviewed**

Optimum Chiropractic, LLC 2020

AUTHORIZATION TO CONSENT TO TREATMENT

Dear Parent(s):

State law requires that you consent to most medical treatments for your minor child.

If an adult other than your child's parent or legal guardian accompanies him/her to office visits, we will be unable to provide treatment without your written authorization, except in emergency situations.

To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

AUTHORIZATION

I, ___________________________________authorize the following individual(s),
(Name of Parent or Legal Guardian)

Name: __________________________________ Relationship to child: ______________________________

Name: __________________________________ Relationship to child: ______________________________

to consent to medical treatment for my minor child/children listed below:

Name: __________________________________ Date of birth: ______________
Name: __________________________________ Date of birth: ______________
Name: __________________________________ Date of birth: ______________

LIMITATIONS

Identify any limitation on the kinds of medical services for which this authorization is given. If none are specified, no limitations will be applied.

____
____

Identify any limitations on the time frame for which this authorization is given. If none are specified, no limitations will be applied.

____
____

PARENTAL CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: __________________________ Parent's Name: ____________________________
Daytime Phone: _________________________ Daytime Phone: ___________________________
Cell Phone: _____________________________ Cell Phone: _______________________________

____ _____________
Signature of Parent or Legal Guardian Date

Optimum Chiropractic LLC **Dr. Mark Munchel**
19904 Augusta Drive Unit 2 Lawrenceburg IN 47025 (812)-577-9518]
Optimumchirorpactic.com optimumchiropracticllc@gmail.com

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff.

YOUR RIGHTS:

1. To inspect or obtain a copy of your records, usually within 30 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: U.S. Dept. of Health and Human Services, Office of Civil Rights 200 Independence Avenue, SW, Washington DC 20201 877-696-6775 www.hhs.gov/ocr/privacy/hipaa/complaints

I hereby acknowledge I have read and received a copy of Optimum Chiropractic Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice. I am aware an extended detail version of this "Notice" is available to me upon request. At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: ____ Date: ________________________

Print Name: ____ Telephone: ____________________

If not signed by the patient, please indicate relationship: ____

Name of Patient: ____

For Office Use Only

Signed form received by: ____

Reason acknowledgment not obtained: ____

Efforts to obtain: ____

PATIENT'S NAME: ______________________________________ HR#: _____________