Pediatric New Patient

Patient First Name: ______________________________ Date of Birth:______________________

Patient Last Name: ______________________________ Gender: ______________________

Parent / Guardian First Name: ______________________ Last Name: ______________________ Date of Birth:____________

Address:____ City:________________ State: _______ Zip:____________

Email:______________________________________ Consent to email appointment reminders & office updates : □ Yes □ No

Home Phone:______________________________

Cell Phone:______________________________

How did you hear about us?

□ Friend who is a patient ______________________________________

□ Internet Search □ Event □ Social Media □ Drive By □ Other

1. **Reason for Chiropractic Care**:____

Other Doctors Seen for this Condition: □ No □ Yes, Name of Doctor: ______________________________________

Check any of the following conditions **your child** has suffered from during the past six months: □ N/A

□ Ear Infections	□ Reflux/ Excessive Spit Up	□ Chronic Colds	□ Constipation
□ Scoliosis	□ Asthma/Allergies	□ Stomach Pain/Gassy	□ Headaches
□ Seizures	□ Food Sensitivities	□ Hyperactivity	□ Growing / Back Pains
□ Temper Tantrums	□ Sensory Processing Issues	□ Colic	□ Bed Wetting

□ Other: ____

Has child been evaluated for tongue and lip tie? □ No □ Yes, has it been revised? □ Yes □ No

2. Birth History

Did you deliver in a hospital? □ No □ Yes;

Name of Hospital: ____

Were there any problems/complications during labor? □ No □ Yes;

If yes, explain: ____

Name of Midwife or Obstetrician: ____

Infant's gestational age:

□ Preterm ; _______ wks

□ Full Term

□ Post-term; ______wks

Initial feeding of baby:

□ Breast; any pain with latching or difficulty feeding on one side

□ Yes □ No

□ Bottle; was breast feeding attempted □ Yes □ No

Birth Weight;

____

Birth Length;

____

Any use of instrument assisted tools during delivery?

□ No

□ Yes; □ Forceps □ Vacuum

Type of Delivery:

□ Vaginal

□ C-section

□ VBAC

GEORGIA
CHIROPRACTIC & MASSAGE

AUTHORIZATION AND ASSIGNMENT
AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his/ her staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/ her of any consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

I authorize the following health care professional, medical facility, medical records service, employer, family member, etc. to receive information regarding my entire medical record, treatment records, and diagnostic records:

Person/Organization to Release Information:____ Relationship: _________________

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Person/Organization to Release Information:____ Relationship: _________________

TERMS OF ACCEPTANCE

I have read, or have had read to me the Terms of Acceptance, Patient Informed Consent, Healthcare Authorization Form, Right to Revoke Authorization Form, Insurance Disclaimer, Beneficiary Agreement, and the Notice of Privacy Practices for Protected Health Information. I have also had the opportunity to ask questions about its content and my signing this authorization I agree to the named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Georgia Chiropractic & Massage, PC

Authorization

The person signing below must be over the age of 18 and a parent or legal guardian

with authority to act on behalf of named applicant

Signature: ____ Date ______________________

First Name (OF SIGNER): ______________________ Last Name (OF SIGNER): __________________ Date of Birth (OF SIGNER): __________

Description of Authority to act on patient behalf: _____________________________ Social Security (last 4 only) -____________

Space Reserved for Doctor Notes: