

North Texas Spinal Health & Wellness

Pediatric New Patient Form

In order to provide you the best wellness care, please complete this form in it's entirety.
All information is strictly CONFIDENTIAL.

Patient Information

Today's Date: _____ Name: _____

Male Female Age: _____ Birth Date: _____

Address: _____ City: _____ State _____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____

Your email will NOT be shared with any 3rd parties, and is used for general office announcements and promotions.
We won't spam you, promise!

Who may we thanks for referring you? _____

Has your child previously had chiropractic care? Yes No How long ago? _____

Family Information

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Parent's Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed

Do one or both parents have custody? _____

Ages of other children in the family: _____

Emergency Contact

Name: _____ Relationship: _____

Work Phone: _____ Home Phone: _____

Account Information

Person Ultimately Responsible for this account.

Name: _____ Relation: _____

Billing Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Driver's License # _____ Social Security # _____

Payment Method: Cash Check Credit Card _____ (Type)

_____ / ____ / ____
Credit Card Number Expiration Date

I understand that outstanding balances of more than 30 days will be charged to this account. _____

Initials

Insurance Company _____ Plan/Group # _____

Name of Insured on Policy _____ DOB of Insured _____

Consent to Evaluate and Treat a Minor

I, being the parent or guardian of _____, a minor, the age of _____, do hereby consent, authorize and request North Texas Spinal Health & Wellness, Inc. and/or the Staff Doctor(s) of this clinic to administer such treatment deemed advisable, including but not limited to examinations, radiological exams, and/or treatment. I agree that I will be responsible for any bill incurred on behalf of the above named individual.

A photocopy of this form associated signature(s) shall be considered as effective and valid as the original.

Parent/Guardian Signature: _____ Date: _____

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause, and others to prevent future ailments. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Pain Relief Correction of Problem Prevention Let the doctor decide

NTSHW Pediatric Health History

(Please complete all questions to the best of your knowledge)

Please check reasons for pursuing chiropractic care for your child:

- She/He is continuing ongoing care from another chiropractor.
 - I recently had my spine checked and I see the value in getting my child checked.
 - I'm concerned about his/her health and I'm looking for answers.
 - She/He has a specific condition that concerns me.
- Explain condition or symptom:
-
-
-

- I want to improve my child's immune function.
- I have no idea why we're here. Please take the time to explain to me what you do for children.

In order for us to better understand your child's current level of health, please check any of the following body signals which your child has or has had previously:

- Headaches
 - Postural Imbalance
 - Asthma
 - Allergies
 - Ear Infection
 - Scoliosis
 - ADD/ADHD
 - PDD/Autism
 - Seizures
 - Growing/Back Pains
 - Car Accident
 - Digestive Problems
 - Frequent Colds
 - Sinus Problems
 - Bedwetting
 - Colic
- Other: _____
-

List Prescription or Over The Counter Medications Now Taken:

Known Allergies:

Number of doses of Antibiotics Your Child has Taken:

During the past 6 months: _____

Total During his/her lifetime: _____

List reasons: _____

Number of doses of Other Prescription Medications Taken:

During the past 6 months: _____

Total during her/her lifetime: _____

List medications: _____

Prenatal History:

Adopted? ___ No ___ Yes

Complications during pregnancy? ___ No ___ Yes

List: _____

Ultrasounds during pregnancy? ___ No ___ Yes Number: _____

Medications/drugs/caffeine during pregnancy? ___ No ___ Yes

List: _____

Cigarette / Alcohol use during pregnancy? ___ No ___ Yes

Location of Birth: ___ Hospital ___ Birthing Center ___ Home

Birth Intervention: ___ Mother induced ___ Mother medicated (Pitocin, etc.) ___
Cesarian Section

___ Forceps ___ Vacuum Extracted ___ Baby given medication

after delivery: _____

Complications during delivery? ___ No ___ Yes List:

Genetic Disorders or Disabilities? ___ No ___ Yes List:

Breast Fed? ___ No ___ Yes How Long? _____ Formula Fed? ___ No ___ Yes

How Long? _____

Food Allergies or Intolerances? ___ No ___ Yes List:

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child?

___ No ___ Yes List:

Is/Has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? ___ No ___

Yes List: _____

Has your child been seen on an Emergency Basis? ___ No ___ Yes

List: _____

Prior Surgery? ___ No ___ Yes

List: _____

Has your child been involved in a motor vehicle accident? ___ No ___ Yes

How long ago? _____

Does your child have any other health problems that concern you? ___ No ___ Yes

If yes, please explain: _____

It is well known that families who maintain strong, healthy, well-maintained spines have much improved health. We appreciate your willingness to allow us to help your child start out life by living better, feeling healthier, and avoiding unnecessary and preventable spinal problems.

The information recorded above is true and accurate to the best of my knowledge.

Parent/Guardian Signature

Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature of Parent/Guardian

Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

PATIENT
NAME

North Texas Spinal Health & Wellness
Dr. Brandon B. Wilson
12398 FM 423 Ste 300
Frisco, Texas 75034
(972) 712-5556

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

♦ **The nature of the chiropractic adjustment.**

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

♦ **The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

♦ **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

♦ **Ancillary treatment.**

In addition to chiropractic adjustments, I intend to use the following treatments:

These treatments involve the following additional significant risks:

♦ **The availability and nature of other treatment options.**

Other treatment options for your condition include:

- ♦ Self-administered, over-the-counter analgesics and rest
- ♦ Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
- ♦ Hospitalization with traction
- ♦ Surgery

The material risks inherent in such options and the probability of such risks occurring include:

- ♦ Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
- ♦ Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.
- ♦ Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
- ♦ The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mis- hap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.
- ♦ **The risks and dangers attendant to remaining untreated.**
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Brandon Wilson and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ DATE _____

Printed Name

Signature

WITNESSES

Signature of Parent or Guardian (if a minor)

Printed Name

Signature

****NOTICE****

PLEASE PRINT THIS PAGE AND BRING WITH YOU, BUT DO NOT FILL OUT

CONDITION OF PATIENT AT TIME OF CONSENT PROCESS

Based on my personal observation and direct conversation with the patient, I conclude that throughout the consent process he was:

- Oriented as to time and place
- Coherent and lucid
- Receiving medication but unimpaired
- Able to understand the language used
- Assisted in understanding by use of an interpreter
(Interpreter's Name _____)
- Assisted in consent process by family members

Name Relationship

- Assisted in consent process by staff members

Name

Patient had the following questions and was supplied with the following answers:

COMMENTS:

I certify that the above accurately describes the consent process in this case.

DATE

Signature of Doctor

Witness Signature



Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Signature

Date