Chase Chiropractic Center
29050 Harper Ave. St. Clair Shores, MI 48081
586-774-0091 chasechiro.net clinic@chasechiro.net

Date _____
Childs Name _____
Nickname _____ Sex M F
Reason for Visit _____
_____
_____
Birth date ___/___/_____ Age _____ Grade____
School _____
Child Address _____
_____
Phone Number (_____) _____ - _____

Who is accompanying the child today?
Name _____
Relationship to Child _____
Are you the legal guardian? _____

Childs Medical History
List any Allergies _____
_____
_____
List Medications _____
_____
_____
List Supplements _____
_____
_____

Has your child had any of the following?
Measles ___/____ German Measles ____/____
Chicken Pox ___/ ____ Mumps ____/____
Pneumonia ___/____

List any diseases _____
_____
_____
_____

Birth Weight _____ Length _____
Age sat up _____ Stood up _____
Walked _____ 1st Spoke _____
1st Tooth _____ Toilet Trained _____
Formula Y N Breast Fed Y N
Vitamins Y N Fluoride Y N

Family Information
Parents marital status (please circle)
Single Married Divorced Widow Separated

Mothers Name _____
Biological Stepmother Guardian Adopted
Mothers Health Good Fair Poor
Birth Date ___/___/_____
Phone # (_____) _____ - _____
Employer _____
Work Phone # (_____) _____ - _____

Fathers Name _____
Biological Stepfather Guardian Adopted
Fathers Health Good Fair Poor
Birth Date ___/___/_____
Phone # (_____) _____ - _____
Employer _____
Work Phone # (_____) _____ - _____

Who is responsible for making appointments?
Mother Father Child

Please list any other children, include birthdates and genders _____
_____
_____

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INFORMED CONSENT TO CHIROPRACTIC CARE

This constitutes informed consent for medical, physical therapy, and/or chiropractic care. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Chase Chiropractic Center. I understand, and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Initial _____

FINANCIAL AGREEMENT & APPOINTMENT POLICY

We, the staff at Chase Chiropractic thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship.

Understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service.

We ask for your assistance and cooperation in keeping your scheduled appointment date and time. It is Chase Chiropractic Center's policy that if the patient, no-shows or cancels an appointment with *less than 24 business hours' notice,* the patient will be charged a **$25.00 fee** (subject to change). If a need arises to cancel or change your appointment, please give the office a minimum of 24 hours' notice. Please note Monday appointments must be cancelled by 5pm on Friday.

We thank you for your cooperation and look forward to be a vital part of your recovery and maintenance.

Initial _____

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ACKNOWLEDMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF CHASE CHIROPRACTIC CENTER

I acknowledge that I was provided a copy of the Notice of Privacy Practices found in the office waiting room. I acknowledge that I have read them, or declined the opportunity to ready them, and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Chase Chiropractic Center to ensure the privacy of my personal health information. I understand that this will be placed in my member chart and maintained until my further notice.

Initial _____

Please list below names of relationships to people to whom you authorize Chase Chiropractic Center to release your private health information.

Print Name	Relationship
_____	_____
_____	_____
_____	_____

_____ _____
Signature/Guardian signature if under 18 Date

_____
Patient name (please print)