PEDIATRIC PATIENT INFORMATION

CHILD'S NAME: ______________________________ MOTHER'S NAME: ________________________________ DOB:____________________________________

CASE NUMBER: ______________________________ FATHER'S NAME: ________________________________ DOB: ___________________________________

ADDRESS: __________________________________ CITY/TOWN: _____________________________ STATE: ______________ ZIP: ______________________

HOME PHONE: ______________________________ MOTHER'S WORK PHONE: _____________________ MOTHER'S CELL PHONE: __________________________

EMAIL: ____________________________________ FATHER'S WORK PHONE: _______________________ FATHER'S CELL PHONE: __________________________

BIRTH DATE: __________________ AGE: ___________ SEX: ___________ NUMBER OF SIBLINGS: __________ REFERRED BY: ____________________________

BIRTH WEIGHT: _______________ BIRTH LENGTH: ___________________ CURRENT WEIGHT: _____________________ CURRENT LENGTH: _________________

THIRD TRIMESTER PRESENTATION: VERTEX ______________ BREECH _______________ TRANSVERSE ________________ FACE/BROW _____________________

TYPE OF BIRTH: NORMAL VAGINAL _____________ FORCEPS _______________ CESAREAN _______________ SUCTION CAP OR VACUUM _____________

LOCATION: HOME ______________ BIRTHING CENTER ___________________ HOSPITAL ____________________

PROBLEMS DURING PREGNANCY: ____

PROBLEMS DURING LABOR/DELIVERY: ____

APGAR SCORES: _________ __________ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)? ______________ CYANOSIS (BLUE)? ____________________

CONGENITAL ANOMALIES/DEFECTS? ___________ IF YES, PLESE EXPLAIN: ____

INFANT FEEDING: BREAST ____________ BOTTLE ____________ IF BOTTLE, WHICH FORMULA? ____

NUMBER OF HOURS SLEEPING PER NIGHT: ________________ QUANTITY OF SLEEP: GOOD ____________ FAIR ______________ POOR ____________________

OBSTETRICIAN/MIDWIFE: ____

PEDIATRICIAN/FAMILY MD: ____

DATE OF LAST VISIT: _______ _______ __________ PURPOSE: ____

IMMUNIZATION HISTORY: ____

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: DURING THE PAST SIX MONTHS __________ DURING HIS/HER LIFETIME: ________________________

PREVIOUS CHIROPRACTOR: ____

DATE OF LAST VISIT: ______ ______ __________ PURPOSE: ____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? ____________ IF YES, PLEASE EXPLAIN: ____

PURPOSE OF THIS APPOINTMENT: ____

INSURANCE/BILLING INFORMATION: ________________________________ POLICY #: ________________

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AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY
TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OF GUARDIAN).

SIGNED: ___________________________________ WITNESSED: _______________________________ DATE: _____ _____ ________

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I AGREE TO PAY FOR ALL SERVICES PROVIDED.

SIGNED: ____ DATE: ______ ______ __________

PEDIATRIC CASE HISTORY

DELIVERY/BIRTH HISTORY: ____
____
____
____

AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND: ____________________ FOLLOW AN OBJECT WITH HIS/HER EYES: ____________________ HOLD HEAD UP: ____________________

SIT ALONE: ______________________ CRAWL: ________________________ STAND: ______________________ WALK ALONE: ______________________

AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES:

CHICKENPOX: _______________________ MUMPS: ________________________ MEASLES: ____________________ RUBELLA: ______________________

RUBEOLA: __________________________ WHOOPING COUGH: _____________________________ OTHER: _____________________________________

HAS THIS CHILD EVER SUFFERED FROM:

- HEADACHES
- DIZZINESS
- FAINTING
- SEIZURES/CONVULSIONS
- HEART TROUBLE
- CHRONIC EARACHES
- SINUS TROUBLE
- ASTHMA
- COLDS/FLU
- COLIC
- ORTHOPEDIC PROBLEMS
- NECK PROBLEMS
- ARM PROBLEMS
- LEG PROBLEMS
- JOINT PROBLEMS
- BACKACHES
- POOR POSTURE
- SCOLIOSIS
- WALKING TROUBLE
- BROKEN BONES
- DIGESTIVE DISORDERS
- POOR APPETITE
- STOMACH ACHES
- REFLUX
- CONSTIPATIOIN
- DIARRHEA
- DIABETES
- HYPERTENSION
- ANEMIA
- BED WETTING
- BEHAVIORAL PROBLEMS
- ADD/ADHD
- RUPTURES/HERNIA
- MUSCLE PAIN
- GROWING PAINS
- ALLERGIES TO____________
- ALLERGIES TO ____________
- ALLERGIES TO ____________
- OTHER _________________
- OTHER _________________

HAS THIS CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?

- FALL IN BABY WALKER
- FALL FROM CRIB
- FALL FROM HIGHCHAIR
- FALL FROM CHANGING TABLE
- FALL FROM BED OR COUCH
- FALL OFF SWING
- FALL OFF SLIDE
- FALL OFF MONKEY BARS
- FALL OFF SKATEBOARD OR SKATES
- FALL OFF BICYCLE
- FALL DOWN STAIRS
- OTHER _________________

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? _______________ IF YES, PLEASE EXPLAIN: ___________________________________
____

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT: _______________ IF YES, PLEASE EXPLAIN: ____
____

PRESENT HISTORY: ____
____
____
____

SURGERY: ____

MEDICATIONS: ____

ACCIDENTS: ____

FAMILY HISTORY: ____

Robinson Family Wellness Patient Financial Policy

The goal of Robinson Family Wellness is to render care within our realm of expertise to stimulate your innate ability to heal. We will give 100% of our energy to accomplish this and do our best to prevent financial constraints from interfering with your ability to receive care. To prevent misunderstandings about the financial aspects of care, the following discloses our financial policy.

PATIENTS WITH HEALTH INSURANCE COVERAGE

During your visit with us, we will verify your insurance coverage to see if chiropractic (and if necessary, out-ofnetwork)
care is covered and any limitations that exist. We will explain this to you, and then bill the insurance for the services provided. You are expected to pay your “co-pay” or the portion that your insurance doesn’t cover **on the date of service.** If, for some reason, your insurance does not pay for a particular visit, those charges are then your responsibility. It is therefore prudent for you to understand your insurance policy and contact your insurance promptly with any questions or problems. However, we do reserve the right to no longer bill your insurance company, if that company is unreasonably difficult to work with.

PATIENTS PAYING OUT OF POCKET/ “CASH” PATIENTS

Cash, checks, and credit cards are accepted and payment is expected at the time of service. In this case, we offer a **“date of service discount”**, due to the reduced administrative cost and handling. However, this does not include supplies or supplements. Legally, we can only grant this discount if the patient pays **prior to or on the day** of service. If you are unable to pay at the time of service, we will be unable to give you the discount and you will be charged the full price due to the administrative costs and handling of your account.

PATIENTS WITH AUTO/WORKER’S COMPENSATION CLAIMS

For patients under care relative to an automobile accident or injury on the job, insurance will cover the cost of care in most cases. We are required to bill *your* auto insurance (or the insurance of the driver of the vehicle in which you were riding) or your WC insurance. Nutritional supplements and some orthopedic equipment, if recommended, are not paid for by insurance and are the patient’s financial responsibility. If/when your insurance discontinues paying for your treatment, **you are then responsible for payment** of your care. If necessary, a monthly payment plan may be arranged. If you decide to get legal aid, we will hold payment until settlement of your claim as long as you are using one of the attorneys we strongly recommend.

CANCELLATION POLICY

If you must miss your scheduled appointment, it is best to reschedule as soon as possible. We have a **24 hour cancellation policy**. A fee equal to the fee of the appointment will be incurred if we do not receive advanced notification of at least 24 hours. Insurance does not cover this fee. It will be your responsibility.

OUTSTANDING BALANCE POLICY

Patients will receive a monthly fee of $5 if their account has a balance that is 90+ days overdue and no payments are being made on it. Overdue accounts will not receive this fee if regular payments are being made to the account. If no payment is made after 180+ days, we unfortunately will need to send the account to collections. Please speak to the office manager if you have any concerns regarding this policy.

I have been informed of and understand this financial policy and agree to it’s terms. I understand that unless specific arrangements are made with Robinson Family Wellness, I am responsible for any balance acquired on this account. I understand that if I discontinue care, all charges are due and payable immediately.

____________________________ ____________________

Patient’s Signature Date

____

Patient's Printed Name