Owego Chiropractic, P.C.
115 Temple Street, Owego NY 13827
(607)687-3800

Infant Patient Information

Patient Name

Last_____First_____Middle Initial_____
Name you prefer to be called by (nickname)_____
Gender M F (circle one) Date of Birth____/____/_____Age_____SS#_____ _____ _____
Home Address_____
City_____State_____Zip_____
Home Phone_____Work Phone_____
Cell Phone_____Cell Phone Carrier_____
Email (home)_____Email (work)_____
Preferred method(s) of contact: (check all that apply)
Email (home)_____(work)_____ Phone (home)_____(work)_____(cell)_____
Would you want to be contacted by Text?_____ or receive emails from us?_____
Employer_____Occupation_____
Employer Address_____
Marital Status: married_____single_____divorced_____separated_____widowed_____
Spouse Name:_____

Who Referred you to this office_____

Emergency Contact

Name_____Relation to Patient_____
Number(s)where can be reached_____

If you are acting on above patient's behalf please fill out:

Last name_____First_____Middle Initial_____
Relationship to patient_____
Gender M F Date of Birth____/____/_____SS#____ ____ _____
Home Address_____
City_____State_____Zip_____
Home Phone_____Work Phone_____
Cell Phone_____Email_____
Employer_____Occupation_____
Employer Address_____

My Certification

I certify that the above information is correct and I request services.

X_____ _____
Signature of patient or person acting on patient's behalf Date

My Privacy

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1. Conduct, plan and direct my treatment and follow-up among healthcare providers who may be directly and indirectly involved in providing my treatment; 2. Obtain payment from third-party payers; 3. Conduct normal healthcare operations such as quality assessments and accreditation.

X_____ _____
Signature of patient or person acting on patient's behalf Date

Insurance Information

My Responsibility

I understand that it is my personal responsibility to verify the chiropractic benefits of my health care coverage before I visit this office.
I also understand that I am personally responsible for all services not paid for by my insurance. All balances unpaid after 60 days will be charged at a rate of 18% annually, 1.5% per month.

Patient Information

Last Name_____First_____Middle Initial_____
Relationship to Insured ◘Self ◘Spouse ◘Child ◘other_____

Primary Insurance Information

Policy Holder Information:
Last_____First_____Middle Initial_____
Date of Birth_____/_____/_____Employer_____
Address (if different from patient)_____
_____
Name of Insurance Provider_____
ID #_____Group #_____
Effective Date____/____/_____
Deductible? (calendar / fiscal) $_____Met? ◘Yes ◘No
Co-pay? ◘Yes ◘No If Yes, Amount $_____
Visit limits per year? (calendar / fiscal) # per year_____Met? ◘Yes ◘No

Secondary Insurance Information (if applicable)

Policy Holder Information:
Last_____First_____Middle Initial_____
Date of Birth_____/_____/_____Employer_____
Address (if different from patient)_____
_____
Name of Insurance Provider_____
ID #_____Group #_____
Effective Date____/____/_____
Deductible? (calendar / fiscal) $_____Met? ◘Yes ◘No
Co-pay? ◘Yes ◘No If Yes, Amount $_____
Visit limits per year? (calendar / fiscal) # per year_____Met? ◘Yes ◘No

My Authorization

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

X_____ _____
Signature of patient or person acting on patient's behalf Date

Pediatric Questionnaire

To Parent/Guardian: Please answer these questions about your child as completely as possible.

General Information:

Patient Name:_____
Male_____Female_____

Present Health History:

Recent falls_____
Recent accidents_____
Major illnesses_____
Previous surgery and/or fractures_____
_____
Is there a health problem at present?_____
If so, what is the problem?_____
_____
When did it start?_____
What possibly caused the problem?_____
_____
If there is pain, could you describe it?_____
_____
Has the pain spread to other parts of the body?_____
If so, where is it found?_____
Is it getting worse?_____
What makes the problem worse?_____
What makes the problem better?_____
Has a chiropractor or doctor been consulted?_____
Are medications being taken at present?_____

Past Health History:

Pregnancy

Maternal health?_____Length of term?_____
Weight gain?_____Exercise?_____
Medications?_____
Alcohol, coffee, cigarettes, chocolate taken?_____

Delivery

Home delivery?_____Length of labor?_____Epidural?_____
Episiotomy?_____Forceps delivery?_____
Other complications?_____
Birth weight?_____APGAR score? (if known)_____

Postnatal Nutrition

Breast-fed or formula?_____To what age?_____
Appetite?_____Colicky?_____Vomiting or diarrhea?_____
Age began solids?_____Food dislikes?_____

Growth and Development

Age crawling?_____Age able to stand?_____Age walking?_____
Was walker used?_____Jolly jumper?_____
Age of first word?_____Age of first tooth?_____
Toilet training age? (daytime)_____(nighttime)_____
Was bed wetting a problem?_____To what age?_____

Personality (check if apply)

Easygoing_____Aggressive_____Hostile_____
Passive_____Energetic_____Hyperactive_____
Other (explain)_____

Immunizations

Diphtheria_____Pertussis_____Polio_____Tetanus_____
Mumps_____Measles_____Other_____

Family History (list major illnesses)

Parents_____
_____
Brothers/Sisters_____
_____
_____

General Health Information:

Have there ever been any convulsions or fainting spells?_____
Problems with walking or hand/eye coordination?_____
Nosebleeds or bleeding gums?_____
Frequent coughs or colds?_____
Squinting or hearing problems?_____
Constipation?_____
Jaundiced or anemic appearance?_____

Name of the person filling out this questionnaire (print)_____
Relationship to patient_____

Signature_____ Date_____

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INFORMED CONSENT TO TREAT A MINOR CHILD

I hereby authorize the performance of chiropractic treatment, and/or other related treatment or procedure, by Owego Chiropractic, P.C.

I understand, as with any health care procedure, that there are certain risks or complications which may arise during chiropractic treatment. I do not expect the attending doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which he/she feels at the time, based upon the facts then known, that are in the best interest of the patient.

I hereby consent to treatment being administered to my:

_____(indicate relationship to child),

_____,
(full name of child)

on_____,
(date)
by_____,
(attending physician)

Signature of consenting adult:_____

Printed name:_____

Signature of witness:_____

Printed name of witness:_____

Dated:_____,20_____