



Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Cell: _____ Carrier (for texts): _____

Home: _____ Work: _____

Sex: _____ Weight: _____ Height: _____ Birth Date: _____

How Did You Hear About Us?: _____

Names of Parents/Guardians: _____

Purpose of Visit? _____

Other Doctors Seen for this Condition: Y N Doctors Names and Prior Treatment: _____

Other Health Problems? _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

- | | | | | |
|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing/Back Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other _____ |

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: ____/____/____ Reason: _____

Are you satisfied with the care your child received there? Yes No

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months _____ Total During Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months _____ Total During Lifetime: _____ List: _____

Vaccination History: _____

PRENATAL HISTORY

Name of Obstetrician/Midwife: _____

Complications during Pregnancy? Yes No List: _____

Ultrasounds during Pregnancy? Yes No Number: _____

Medications during Pregnancy/Delivery: Yes No List: _____

Cigarette / Alcohol Use During Pregnancy: Yes No

Location of Birth (Circle one) Hospital Birthing Center Home Other _____

Birth Intervention: (Circle All That Apply) Forceps Vacuum Extraction Epidural

Spontaneous Vaginal Birth: Yes No Cesarean Surgery: Yes No (Emergency or Scheduled?)

Complications During Delivery? _____

Genetic Disorders or Disabilities? _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

4609 South Main Street, Acworth, GA 30101

Phone: (770) 966-1800 Fax: (770) 966-0413

FEEDING HISTORY

Breast Fed Yes No How Long: _____
Formula Fed Yes No How Long: _____ Type: _____
Introduced to solids at: _____ Months Cow's Milk at: _____ Months
Food / Juice allergies or intolerances: Yes No List: _____

DEVELOPMENTAL HISTORY

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

_____ Respond to Sound _____ Cross Crawl _____ Respond to Visual Stimuli
_____ Stand Alone _____ Hold Head Up _____ Walk Alone _____ Sit up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? No Yes

Has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? Yes No List: _____

Has your child ever been involved in a car accident? Yes No List: _____

Has your child ever been seen on an emergency basis? Yes No List: _____

Other traumas NOT described above? Yes No List: _____

Prior Surgery: Yes No List: _____

CHILDHOOD DISEASES

Chicken Pox Yes No Age _____ Mumps Yes No Age _____
Rubella Yes No Age _____ Pertussis Yes No Age _____
Rubeola Yes No Age _____ Other Yes No Age _____
List: _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company _____ Policy# _____

Signed _____ Witnessed _____

Date _____ DOB of Policy Holder: _____



TERMS OF ACCEPTANCE

If a patient seeks chiropractic care and we accept a patient for such care, it is essential for both of us to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO CARE

I do hereby authorize the doctors of Ferguson Family Chiropractic to administer such care that is necessary for my particular case. This may include consultation, examination, adjustments, or any other procedure which is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____ have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Signature: _____ Date: _____

Signature of parent or guardian if minor



HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information.

The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request a copy if you would like one.

This Notice of Privacy Practice also describes my rights and duties of the chiropractor with respect to my Protected Health Information. I hereby give permission to Ferguson Family Chiropractic (FFC) to use and/or disclose Protected Health Information in accordance with the following.

SPECIFIC AUTHORIZATIONS

- I give permission to FFC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointments notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If FFC contacts me by phone, I give them the permissions to leave a phone message on my answering machine or voice mail.
- I give permission to FC to use my name on a welcome board, referral board and birthday board.
- I give permission to FFC to use my photograph on the patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to FFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on the their website or in ads in print media.
- I give FFC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving FFC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance you access to quality health care and health information. This authorization will remain in effect for the duration of my care at FFC plus 7 years or until revoked by me.

(page 1 of 2)

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action to reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of FFC. The written notice must contain the following information:

- Your name, Social Security number & date of birth;
- A clear statement of you intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by FFC for its own use/disclosure of PHI. (Minimum necessary standards apply)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, FFC will not refuse to provide treatment however, it will not be possible for FFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since FFC will be unable to contact me 3) all contact with FFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or cop, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: _____ DOB: _____
 My Name (please print): _____
 My Signature: _____
 Today's date: _____

Name of personal Representative (if someone is designated to act on your behalf)

Name (please print): _____
 Signature of Personal Representative: _____
 Description of Representative's Authority to Act on Patients Behalf: _____