Dr. Shawn Carlin

"Gentle Chiropractic for the Whole Family"

PEDIATRIC HISTORY

Dear New Patient, **Date: _____**

It is a pleasure to welcome you to our family and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name : _____S.S.#:_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____

Email: _____Birthdate:_____/_____/_____

Cell Phone:_____ Work Phone:_____

Sex:_____ Weight:_____ Height:_____ Referred By:_____

Names of Parents / Guardians: _____

Purpose For Contacting Us : _____

Other Doctors Seen for this Condition:_____N _____Y

Doctor's Names and Prior Treatments:

_____

_____

Other Health Problems : _____

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

___ Ear Infections ___ Scoliosis ___Seizures ___ Chronic Colds ___ Headaches

___ Asthma / Allergies ___ Digestive Issues ___ ADHD ___ Recurring Fevers ___ Growing/Back Pains

___ Colic ___ Bed Wetting ___ Car Accident ___ Temper Tantrums ___ 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 has received there? _____ Y _____ N

Number of Doses of Antibiotics Your Child has Taken:

During the past six months : _____ Total during his/her lifetime : _____

Number of Doses of other prescription medications Your Child has Taken:

During the past six months : _____ Total during his/her lifetime : _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications during pregnancy? _____ N _____ Y , List: _____

Ultrasounds during pregnancy? _____ N _____ Y , Number: _____

Medications during pregnancy/delivery ? _____N _____ Y , List: _____

Cigarette / Alcohol use during pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____Birth Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction _____ Caesarian Section, Emergency or Planned?

Complications During Delivery? _____ Y _____ N , List: _____

Genetic Disorders or Disabilities: _____ Y _____ N , List _____

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

Feeding History:

Breast Fed: _____N_____Y, How Long:_____

Formula Fed:_____N_____Y, How Long_____ Type:_____

Introduced to Solids at:_____Months, Cow's Milk at _____ Months Food /Juice

Allergies or Intolerances:_____N _____Y, 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 which age was your child able to: (Please turn this page over)

_____Respond to Sound _____Cross Craw

_____Respond to Visual Stimuli _____ Stand Alone

_____ Hold Head Up _____Walk Alone

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, downstairs, etc.). Was this the case with your child? _____N _____ Y.

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc. ? _____N_____Y. List:_____

_____

Has Your Child Ever Been Involved in a Car Accident? _____N _____Y. List:_____

Has Your Child Been Seen on an Emergency Basis? _____N_____Y.
List:_____

Other Traumas Not Described Above? _____N _____Y. List:_____

Prior Surgery: _____N _____Y List:_____

Menarche: _____N _____Y Age:_____

Childhood Diseases:

Chicken Pox N / Y, Age _____ Mumps N / Y, Age _____

Rubella N / Y, Age_____ Whooping Cough N / Y, Age _____

Rubeola N /Y, Age_____ Other_____ N / Y, Age_____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctor to administer care to my Daughter /Son 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_____/_____/_____

Dr. Shawn Carlin

"Gentle and Effective Chiropractic"

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patients understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to; muscle or ligament injuries, nerve injuries, vascular injuries and fractures. Alternatives to chiropractic care may include medications, surgery, and other alternative treatments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above informed consent and hereby grant permission for my child to receive chiropractic care.

FINANCIAL POLICY

Dr. Shawn Carlin

It is the policy of this office that PAYMENT IS DUE AT THE TIME OF SERVICE.

If you have health insurance, one of the following office procedures will apply to you:

For those with **BC/BS insurance,** we are "in-network":

- Full payment is due at the time of service until your deductible is met, after which
- Co-pay or co-insurance is due at the time of service.
- When your benefits are exhausted, you will be charged our discounted cash fee at time of service.

For all other insurance carriers, we are "out-of-network:

- Our discounted "cash" fee is to be paid at the time of service and
- You will be provided with a "Superbill" which you can submit to your insurance company for reimbursement.
- You will need to confirm with them that chiropractic is covered.
- We do not provide reports or additional documentation to these companies.

We are a non-participatory provider of **Medicare** which means:

- The full Medicare fee is to be paid at the time of service and
- We will submit to Medicare for you. Medicare will then reimburse you.
- In our experience it could take a minimum of 8 weeks for Medicare to process your claim.

If for any reason you are in a "balance due" situation, you will be billed for that amount plus an additional 1.5% on any unpaid balance each month until the balance is fully paid.

We continue to accept CASH, CHECKS, and CREDIT CARDS.

Payment for your care is your responsibility. If you do have insurance, it can be a strong support for you, but ultimately the commitment is between the patient and the doctor. Your care is my commitment to you, and your payment is your commitment to me.

I UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE OF DR. SHAWN CARLIN AND ACCEPT RESPONSIBILITY FOR MY BILL.

Signature of Patient or responsible party. **DATE**