Dodge Family Chiropractic
702 S. Denton Tap Rd Suite 150
Coppell, TX 75019
972-922-5493
dodgefamilychiropractic.com

New Patient Information

Date: _____

Child's Name: _____ Nickname: _____

Reason for Visit: _____

Sex: M / F Date of Birth: _____ Age: _____ Child's SSN: _____

Child's Home Phone Number: _____

Child's Home Address: _____

Referred By: _____

Family Information

Mother's Name: _____ Father's Name: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Parent's Marital Status: Married____ Single ____ Divorced____ Widowed_____

List Ages of Other Children in Family: _____

Predominant language used at home: _____

Consent to Treat

Being the parent or legal guardian of this child, I herby authorize this office and its doctors to examine and administer care to my son/daughter _____, as the examining/treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name: _____Signature: _____

Date: _____ Witnessed by: _____

Payment Information

Please read and sign our Financial Agreement.

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Pregnancy History

Today's Date: _____

Child's Name: _____ Sex: M / F DOB: _____ Age: _____

Mother's Name: _____ Number of Children: _____

Term of Pregnancy: _____weeks

DURING YOUR PREGNANCY DID YOU HAVE ANY OF THE FOLLOWING

Falls	Y / N	_____
Motor Vehicle Accidents	Y / N	_____
Near-miss MVAs	Y / N	_____
High Blood Pressure	Y / N	_____
Diabetes	Y / N	_____
Anemia	Y / N	_____
Morning sickness	Y / N	_____
Indigestion	Y / N	_____
Seizures	Y / N	_____
Swollen ankles	Y / N	_____
Thyroid problems	Y / N	_____
Back pain	Y / N	_____
Abnormal bleeding	Y / N	_____
Were you hospitalized?	Y / N	_____
Any other illnesses	Y / N	_____

DURING YOUR PRENANCY, DID YOU USE ANY OF THE FOLLOWING

Tobacco	Y / N	_____
Alcohol	Y / N	_____
Non-prescribed drugs	Y / N	_____
Prescription medication	Y / N	_____
Over the counter meds	Y / N	_____

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Birth History

How long was labor from the first regular contractions to the birth? _____

How long was the pushing stage of labor? _____

Hospital birth	Y / N	_____
Home birth	Y / N	_____
Midwife assisted	Y / N	_____
Doula present	Y / N	_____
Vaginal Delivery	Y / N	_____
Planned C-section	Y / N	_____
Emergency C-section	Y / N	_____
Induced (pitocin)	Y / N	_____
Forceps delivery	Y / N	_____
Vacuum extraction	Y / N	_____
Anesthesia administered	Y / N	_____
Fetal distress	Y / N	_____
Meconium staining	Y / N	_____
Head presentation	Y / N	_____
Face presentation	Y / N	_____
Breech presentation	Y / N	_____

Baby's Condition Immediately After Birth

Apgar Scores: At 1 minute ____/10 At 5 minutes ____/10

Baby's Crying Baby Cried Immediately After Birth _____

Cried Strongly _____ Weak Cry _____ Did Not Cry for ____ min

Baby's Color Pink all over _____ Blue Face _____ Blue Hands/feet ____

Baby's Activity Arms and legs actively moving _____ Floppy baby ____

Intensive Care Was required ____ Days in Neonatal Intensive Care Unit ____

Medication given at birth? _____ Vaccines administered _____

Birth Weight _____lbs/kgs Birth length _____ in/cm Baby home on day _____

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Today's Date: _____

Patient's Name_____ Sex: M / F

Date of Birth_____ Age: _____

The following questions are designed to help the doctor provide a detailed evaluation of your child.

Nutrition

Y / N Is your child still being breast-fed? If no, for how long was he/she breast fed_____

If yes, how much cow's mild does the mother consume each day? _____

Y / N Is your child formula fed? Which formula or other milk source? _____

Y / N Is your child eating solid food? What foods does his/her diet contain? _____

_____

What is your child's favorite food? _____

Y / N Does your child have any feeding difficulties? _____

Y / N Does your child have any digestive disturbances? _____

Y / N Does your child have any food allergies? _____

Y / N Does your child have any persistent or intermittent skin rashes? _____

Y / N Is your child receiving any vitamin supplements? _____

Trauma

Y / N Has your child had any recent falls or trauma?

Describe the trauma and date it occurred _____

Y / N Has your child ever fallen down stairs or fallen from any height? _____

Y / N Has your child ever been in a motor vehicle accident or near miss _____

Y / N Has your child ever had a bone fracture or joint dislocation? _____

Y / N Has your child had any other trauma or injuries? _____

Y / N Does your child ever bang his/her head repeatedly against a wall, bed or other object? _____

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Growth and Development

Y / N Can your child sit unsupported? What age did your child start sitting up? _____

Y / N Is your child crawling yet? What age did your child start crawling? _____

Y / N Is you child walking yet? What age did your child start crawling? _____

Y / N Does your child often trip and fall? _____

Y / N Do you have any other concerns about your child's growth and development? ____

_____

Health History

Y / N Has your child had colic? _____

Y / N Has your child had any upper respiratory infections? How often? _____

Y / N Has your child had asthma? _____

Y / N Does your child ever complain of back or neck pain? _____

Y / N Does your child ever complain of pains in the arms or legs? _____

Y / N Does your child ever complain of headaches? _____

Y / N Has your child had any earaches? What age did the first earache occur? _____

Y / N How frequently does your child have earaches? _____

Y / N Do your child's earaches usually tend to occur in the same ear? Is it right/left/both?

Y / N Has your child had any other illnesses? List dates and illness: _____

_____

Y / N Is your child presently receiving any medications? _____

Y / N Has your child ever been to a hospital or ER for evaluation or treatment? _____

Y / N Has your child recently been vaccinated? _____

Y / N Do you have any other concerns about your child's health? _____

_____

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INFORMED CONSENT TO EXAMINATION AND CHIROPRACTIC TREATMENT

I, _____ understand that this office does not file my insurance and that any fees incurred for treatments are charged directly to me and are my sole responsibility. I herby authorize the Doctor to perform upon e examination and diagnostic procedures arising from any current or presently unforeseen conditions, which the Doctor considers necessary or advisable in the course of my health care.

The Doctor will be treating his/her patients through any or all of the following: the adjustment of the spine through both low and high force techniques, nutritional counseling, and exercise. The Doctor will utilize various Chiropractic techniques in order to best serve each individual patient. These techniques may include adjustment of the cranial bones, the vertebral column, the pelvis, and the upper and/or lower extremities. The techniques focus on maintaining healthy spinal alignment and motion thereby influencing nervous system function. The Doctor will not directly treat any specific medical conditions.

The material risks inherent in the Chiropractic adjustment:

- As with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment

The probability of those risks occurring

- Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history, examinations and possible x-rays. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

It is important that you understand other treatment options outside of Chiropractic care are available to you.

Other treatment options for you condition may include:

- Self-administered, over-the-counter analgesics and rest.
- Medical care with prescription drugs
- Hospitalization
- Surgery

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The material risks inherent in such options and the probability of such risks include:

- Overuse of over-the-counter medications produces undesirable side effects. Premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications occurring is dependent upon the patient's general health, severity of the patient's discomfort his/her pain tolerance, and self-discipline in not abusing the medication. Professional literature describes highly undesirable effects from long term use of over-the-counter medications
- Prescription medications can produce undesirable side effects and patient dependence. The risk of such complications arising is dependant upon the patient's general health, severity of the patient's illness, Such medications generally entail very significant risks, some with rather high probabilities
- Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induce) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
- The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The risks and dangers attendant to remaining untreated

- Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I, _____ UNDERSTAND THE RISKS INVOLVED IN CHIROPRACTIC TREATMENT, THE OTHER OPTIONS AVAILABLE AND THEIR RISKS, AND THE RISKS OF REMAINING UNTREATED. BY SIGING BELOW I STATE THAT I HAVE WEIGHTD THE RISKS INVOLVED IN UNDERGOING TREATMENT AND HAVE MYSELF DECIDED THAT IT IS IN MY BEST INTEREST (OR SAID MINOR'S INTEREST) TO UNDERGO THE TREATMENT RECOMMENDED. HAVIGN BEEN INFORMED OF THE RISKS, I HEREBY GIVE MY CONSENT APPROPRIATE THROUGH THE USE OF MANIPULATION OF MY SPINE AND EXTREMITIES, NUTRITIONAL CHANGES, AND RECOMMENDED EXERCISES AND ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE AS TO THE RESULTS THAT MAY BE OB TAINED FROM THIS TREATMENT HAS BEEN GIVEN TO ME.

Patient Signature (18 and over): _____ Date: _____

Patient Printed Name: _____

Parent or Guardian Signature (for minors): _____

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FINANCIAL POLICY

Our first concern in this office is to provide you, the patient with excellent chiropractic care and wellness education.

1. Payment for the Initial New Patient Visit with our doctors is required at the time of your first visit to our office. All other payments, including adjustments, nutritional evaluation, allergy clearing, and vitamin/supplements are due at the time that the services are performed. For your convenience we accept cash, checks, MasterCard, Visa, Discover and American Express Credit cards.

2. Because we run a cash practice, we DO NOT file an insurance claims including Medicare. We are currently not providers for Medicare, which means you WILL NOT and CANNOT be reimbursed by Medicare for your visits to our office. Upon request we will print a statement that will provide you and your private insurance carrier with the information necessary to make a claim. If you wish to file a claim you are responsible for contacting your insurance carrier and submitting your claim. Please note that this does not guarantee payment for any part of services rendered. It has been our experience that insurance companies will often deny reimbursement for procedures. It is not uncommon for some insurance companies to deny a claim either at the onset of the patient's acute care or when a patient seeks reimbursement for wellness care. Most insurance companies do not understand wellness care and true holistic prevention. They are allopathic in nature and reimburse accordingly. Please, take the opportunity to educate your insurance providers as to the value of a wellness lifestyle.

3. **Missed Appointment Policy** – Please be sure to give us 24 hours notice if you need to cancel or reschedule your appointment. If patient "No-Shows" (does NOT call or leave a message) or cancels within the 24 hour period a fee in the amount of the visit that was scheduled will be charged.

4. **Automobile Accident Policy** – Our office will be happy to file your Personal Injury case if the insurance company that will be handling your case has approved you. After treatment is finished you then become responsible for your balance whether paid with the insurance check received for treatment or from your own personal account. If the insurance company did not cover all of your treatment you become responsible for the remaining balance.

All questions regarding other financial matters should be addressed with the office manager or Doctor if necessary. We want you to be comfortable dealing with these matters, and we believe open communication will enhance the positive outcome we all desire.

Patient Signature: _____ Date: _____

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AUTHORIZATION TO LEAVE MESSAGES AND CONVEY INFORMATION

Patient Name: _____

It is sometimes necessary for representatives of Dodge Family Chiropractic to contact patients for various notification purposes. The purposes of these communications can range from reminders of appointments, to notify patients that supplements or products they requested are ready for pickup or to ask a patient to call Dodge Family Chiropractic regarding an issue or concern. At no time will a representative of Dodge Family Chiropractic discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household, on your answering machine or voicemail service or through email with your consent below.

You have the right to revoke this consent, in writing, effective the day following your notification

_____ I authorize Dodge Family Chiropractic to LEAVE MESSAGES ON MY ANSWERING MACHINE AND/OR VOICEMAIL USING THE CONTACT NUMBERS I HAVE PROVIDED.

_____ I authorize Dodge Family Chiropractic to LEAVE MESSAGES WITH HOUSHOLD MEMBERS

_____ I authorize Dodge Family Chiropractic to contact me at the following email address:
Email Contact_____

Patient Signature: _____ Date: _____