

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 hereby 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: _____

Name: _____ Sex: M / F Date of Birth _____

Reason for Today's Visit: _____

When did this problem first occur? _____

Y / N Have you ever had this problem before? _____

Y / N Have you previously been treated for this problem? Doctor's Name _____

Y / N Have you previously been to a chiropractor? When? _____

About Your Health

In the past year have you had any of the following:

Y / N Back or Neck pain? _____

Y / N Pains in the legs or arms? _____

Y / N Headaches? _____

Y / N Asthma? _____

Y / N Allergies? _____

Y / N Earaches? _____

Y / N Falls from a bike, skateboard, scooter, rollerblades or similar? _____

Y / N Do you ever have a problem with bedwetting? _____

Y / N Have you ever been in a motor vehicle accident? _____

Y / N Have you ever had any broken bones? _____

Y / N Have you ever had any surgeries? _____

Y / N Are you at present taking any medications? _____

Y / N Do you have any other health problems? _____

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About Your Lifestyle

What grade are you in at school? _____

How do you carry your school books? _____

How heavy is your schoolbook bag? _____

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On average, how many hours sleep do you get each night? _____

Are there any smokers in your family? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you ever have blurred vision? _____

Do you wear glasses or contact lenses? _____

Do you sometimes get headaches when you read? _____

About Your Diet

What do you usually eat for Breakfast? _____

What do you usually eat for Lunch? _____

What do you usually eat for Dinner? _____

What snacks do you have after school? _____

What is your favorite food? _____

How much water do you drink each day? _____

How many sodas or colas do you drink each day? _____

How often do you eat fast food items? _____

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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 hereby 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: _____