NCRC Nelson Clinic and Rehabilitation Care

Infant New Patient Form

PATIENT INFORMATION

Name (First)_____(M)_____(Last)_____

Address_____City_____State_____Zip_____

Phone #_____ Date of Birth_____ Age_____ Gender: ☐Male ☐Female

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CURRENT PRIMARY HEALTH CONCERN

What is your child's main symptom? _____

How long has he/she had this condition? _____

Has he/she had this or similar conditions in the past? ☐ Yes ☐ No When?_____

Over time, is this condition: ☐ Improving ☐ Unchanged ☐ Getting Worse?

How often does your child experience his/her symptoms?

① Constantly (75-100% of the time) ② Frequently (50-75%) ③ Occasionally (25-50%) ④ Intermittently (0-25%)

Check all that apply: ☐Colic ☐Irregular sleeping patterns ☐Tantrums ☐Ear infections ☐Poor digestion ☐Repeated colds

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PATIENT HISTORY

Place of birth: ☐Home ☐Birthing Center ☐Hospital ☐Other:_____

Type of birth: ☐C-section ☐Vaginal

Was ultrasound used during pregnancy? ☐Yes ☐No If yes, how many times?_____

Was labor induced? ☐Yes ☐No If yes, why?_____

Was Anesthesia used? ☐Yes ☐No If yes, what types of Anesthesia?_____

Were there any special medical procedures or tests performed? ☐Yes ☐No If yes, please specify:_____

Is the child breastfed? ☐Yes ☐No If yes, to what age? _____

Any major falls or traumas? _____

Please list medications: _____

For office use only:

Vitals: Ht _____ Wt _____ Temperature _____

		L	R			+	-
ROM:	Rot	/110+	/100+	Ortho:	Ortolani's	( )	( )
	Lat Flex	/70+	/70+		Barlow's	( )	( )
		L	R				
Neuro:	Achilles			Skin Findings:	Normal	Abnormal	
	Patellar				Location _____		
	Bicep						
	Babinski						

OFFICE FEES AND FINANCIAL POLICY

Service	**Fee**
Initial Examination (Child)	No charge!
Adjustment	$52

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees; therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the option that you would prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being and we will do our best to help you.

Insurance: We will verify all insurance and your benefits per your agreement with your carrier. If your insurance covers any or all of care, it will be posted to your account accordingly. Any charge for services NOT covered by insurance is the **patient's** responsibility and will be billed out monthly.

Same Day Discount Policy: Any account considered a CASH account qualifies for same day discount, based on services rendered. All charges must be paid in FULL on the date of service to receive the discount. Any charges not paid on the same day will be billed at the usual service fee. Charges for an office visit will be $40.

PARENT/LEGAL GUARDIAN INFORMATION

First Name: _____ Middle: _____ Last: _____

Phone: _____ Email: _____

Address (if different from above): _____

Agreement: My signature below signifies my understanding that I will be responsible for any charges for services that are not covered by my insurance.

☐ I would like to receive paperless billing at email: _____

I have read and agree to the above statement.

_____ _____

Parent/Legal Guardian Signature Date

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my child through the use of adjustments to his/her spine, as he deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider of services rendered.

_____ _____

Parent/Legal Guardian Signature Date