NUZZI CHIROPRACTIC
LIFESTYLE WELLNESS CENTER

Pediatric History (Under 12)

Date _____

Patient Name_____ Date of Birth _____Sex: M F

Name of Parents/ Guardians _____

Address _____

City _____ State_____ zip code _____

Home phone number _____ Cell number _____

Email Address _____

Primary Language _____ Race _____ Ethnicity _____

Is the child living with: mother father both?

Current Height_____ Current Weight _____

Name of School_____ Grade/level of Education _____

Who referred you to the office/ how did you hear of the office? _____

Reason you are seeking Chiropractic Care for your child? _____

Please list the health concerns for your child: _____

Symptoms: please circle any current problems

Dizziness Diarrhea Broken Bones Sprains/Strains ADHD Backaches Headaches

Heart Conditions Constipation Chronic Ear infections Frequent Colds Asthma Leg pain

Neck pain Arm pain Blood disorder Stomach aches Muscle pain Muscle cramps Anemia

Poor Appetite Rashes Sinus trouble Cough/wheeze Bed wetting Difficulty sleeping Behavior

Hyperactivity Growing pains Joint pain Scoliosis Other_____

Please List any allergies_____

Name of Pediatrician _____

Is your child receiving or received in the past physical therapy, occupational or speech therapy? If so who and when:

_____

Patient Name_____ Date _____

Medications your child is currently taking? _____

_____

Please list any allergies.

_____

_____

Supplementation your child is currently taking? _____

Does your child participate is sports? If so what sport, how often and please rate the intensity of participation:

_____

Has your child been involved in a motor vehicle accident? If so when and how severe:

_____

List all hospitalizations and the reason why: _____

Prenatal History

Where was your child born? _____

Was the birth or pregnancy complicated? If so what was the complication:

_____

Does your child have a genetic disorder? If so please list: _____

Developmental History

Has your child been diagnosed with a below average or abnormal development for crawling, sitting, standing, walking, saying words, coordination of fine motor skills or any other developmental delay? Please explain_____

_____

Please describe your child's sleeping habits:

_____

History of Childhood Disease

Chicken pox y/n Mumps y/n Rubella y/n whooping cough y/n Meningitis y/n

Measles y/n Tuberculosis y/n Other: _____

Is your child's vaccination schedule current? If not what vaccinations has your child NOT received?

_____

Treatment Authorizations and Releases

Patient's Name: _____

Parent / Guardian's Name If Signing For Patient: _____

Consent for Treatment/ Payment Agreement

I, the undersigned, hereby authorize Dr. Lori A. Nuzzi (D.C.) and/or whomever she may designate as assistant(s) or covering physician(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that referrals from my primary care physician, when necessary, are entirely my responsibility and that if one is not obtained I will be expected to pay regardless of my insurance coverage. I understand and agree that if any payments due by me are not made in a timely manner (60 days from initial billing), I will be responsible for late charges, interest of 1 ½% per month, and any applicable collection fees as permitted by law. Furthermore, I understand that any amount authorized to be paid by my insurance will be paid directly to this office and credited to my account. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature: _____ Date / / Witness: _____

Authorization to Release Medical Information

I authorize Dr. Lori A. Nuzzi (D.C.) and/or whomever she may designate as assistant(s) or covering Physician to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall include any and all information necessary to process my insurance claims and remains valid indefinitely. I certify that all insurance information given to this office is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient's Signature: _____ Date: / / Witness: _____.

Request for Payment of Benefits to Provider of Care

I hereby irrevocably authorize my insurance company / insurance administrator to pay by check made out and mailed directly to: Dr. Lori A. Nuzzi, or Nuzzi Chiropractic Family & Sports Center, the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by the above named Doctor of Chiropractic to be released to any representative of their offices. I have agreed to pay, in a current manner, any balance of said applicable charges I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill. I authorize the office to act in my behalf and report any suspected violations of proper claims practices by my insurance company to the proper regulatory authorities.

Patient's Signature: _____ Date: / / Witness: _____

Consent for Treatment of Minor

I hereby authorize Dr. Lori A. Nuzzi (D.C.) and/or whomever she may designate as assistant(s) or covering physician(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as she deems necessary to my: son/ daughter ,Name:_____

Parent/Guardian's Signature: _____ Date: / / Witness: _____

HIPAA Compliance

The office of Dr. Lori A. Nuzzi and its employees may use my health and personal information in any way necessary to obtain payment for services. This includes but is not limited to: filing claims, obtaining pre-authorizations, referrals, and billing outstanding balances. This information may also be shared with my other treating physicians or technicians as necessary. While every effort will be made to keep this information confidential, I understand that some information such as my name or a portion of my name may be used in the presence of others.

Patient's Signature: _____ Date: / / Witness: _____