HOOGEVEEN CHIROPRACTIC WELLNESS CENTER

GREGG HOOGEVEEN, D.C., C.C.S.P. ADAM HOOGEVEEN, D.C., C.C.W.P.
LOGAN HARRE, D.C. BROOKE HARRE, D.C., C.A.C.C.P.

PERSONAL INFORMATION NEEDED TO BETTER SERVE YOU

FIRST NAME OF PATIENT: _____ NICKNAME: _____ LAST NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BIRTHDAY: ____-____-_____ GENDER: MALE FEMALE

SCHOOL ATTENDED (WHEN APPLICABLE) _____

PARENT/GUARDIAN INFORMATION:

MOTHER'S NAME: _____ FATHER'S NAME: _____

HOME/CELL PHONE ____-____-____ HOME/CELL PHONE ---------- _____

WORK PHONE ____-____-____ WORK PHONE ----------_____

PARENT'S MARITAL STATUS: S / M / W / D

EMAIL: _____

REFERRED BY: ☐ PERSON: _____ ☐ DOCTOR: _____ ☐ GOOGLE ☐ YELLOWPAGES
☐ OTHER: _____

WHAT BRINGS YOU IN?

WHAT IS YOUR REASON FOR SEEKING OUR CARE? _____

Symptom Frequency: Constant or _____ times per day/week/month (circle one)
Duration of Symptom: _____ seconds/minutes/hours (circle one)

WHEN DID IT START? _____
HOW DID IT START? _____

WHAT MAKES IT WORSE? _____ **BETTER?** _____

OTHER CARE/TREATMENTS FOR THIS CONDITION/SYMPTOM: _____
PREVIOUS CHIROPRACTIC CARE? ☐ YES ☐ NO REASON FOR SWITCHING: _____

GOALS FOR YOUR CHILD'S CARE: ☐ SYMPTOM RELIEF ☐ RESTORING FUNCTION ☐ OVERALL WELLNESS
(CHECK ALL THAT APPLY) ☐ OTHER: _____

OTHER COMMENTS: _____

"Improving Your Family's Health is Our Family's Mission"

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BIRTH HISTORY (IF PATIENT IS 2 YEARS OR YOUNGER)

WAS YOUR CHILD'S BIRTH **VAGINAL** OR **CESAREAN ?** IF CESAREAN, WAS IT **PLANNED** OR **EMERGENCY?**
WAS THE BIRTH INDUCED?_____ WAS THERE USE OF FORCEPS OR VACUUM? _____
WHAT WAS YOUR CHILD'S PRESENTATION? **HEAD** OR **BREECH** WAS MECONIUM PRESENT? **YES** **NO**
WERE THERE ANY COMPLICATIONS WITH THE PREGNANCY OR BIRTH? IF YES, PLEASE EXPLAIN. _____
_____

OVERALL BEHAVIOR

TELL ME ABOUT YOUR CHILD'S SLEEPING PATTERNS _____
MY CHILD'S DIET CONSISTS MOSTLY OF: (CIRCLE ALL THAT APPLY) MEAT FISH FRUITS VEGGIES DAIRY GRAINS BREAST MILK FORMULA
HIS/HER FAVORITE SNACK IS:_____
MY CHILD LIVES IN A HOME WITH A SMOKER. (CIRCLE ONE) TRUE / FALSE
OVERALL, I BELIEVE THAT MY CHILD IS HEALTHY. (CIRCLE ONE) TRUE / FALSE

MEDICATIONS **ALLERGIES** **SPINAL INJURIES/SURGERIES**

_____ _____
_____ _____

OTHER INJURIES/SURGERIES

_____ _____ _____
_____ _____ _____

IS YOUR CHILD CURRENTLY UNDER THE CARE OF ANY OTHER HEALTH CARE PROVIDER/DOCTOR? ☐ YES ☐ NO
IF YES, FOR WHAT CONDITIONS? _____
NAME OF YOUR PEDIATRICIAN: _____ LOCATION: _____
DO YOU GIVE US PERMISSION TO CONTACT YOUR MEDICAL DOCTOR ABOUT YOUR CHILD'S CASE OR FOR OTHER PERTINENT INFORMATION?
☐ YES ☐ NO IF YES, PLEASE SIGN: _____

Review of Systems

Have you noticed your child feels:

… feverish, excessively fatigued, or had a recent unexpected loss of weight? ❑ YES ❑ NO
… persistent nausea, diarrhea, constipation, chronic abdominal pain, or abnormal stool? ❑ YES ❑ NO
… blurred/double vision, eye pain/discharge, failing vision, or light sensitivity? ❑ Yes ❑ No
… ear pain/discharge, difficulty hearing/swallowing, frequent nose bleeds/sore throat? ❑ Yes ❑ No
… chest pains, fainting spells, irregular heartbeat, shortness of breath, swollen ankles? ❑ Yes ❑ No
… chronic cough, chronic wheezing, coughing up blood, or excessive phlegm? ❑ Yes ❑ No
… painful/bloody/more frequent/uncontrolled urination, unusual genital discharge, genital sores, breast mass/tenderness, excessive menstrual flow/pain, etc? ❑ Yes ❑ No
… weakness, numbness/tingling, seizures/convulsions, tremors/shaking, dizziness? ❑ Yes ❑ No
… skin rashes/itching/chronic dryness, suspicious moles or other patches/markings? ❑ Yes ❑ No
Comments: _____

I _____ hereby affirm that all information I have provided on this patient information form is accurate and complete to the best of my knowledge at this time. I have not intentionally falsified or misrepresented any of the information that I provided above, and if any of this information changes in the future I will inform Hoogeveen Chiropractic Wellness Center as soon as possible.

Signature:_____ Date:____/____/_____
Relationship to patient: _____

Hoogeveen Chiropractic Wellness Center

Statement of Financial Responsibility

Patient Name: _____ Date of Birth: ____/____/____

Hoogeveen Chiropractic Wellness Center appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy and if applicable, we will verify your insurance coverage to the best of our ability and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. If other arrangements need to be made, please advise our front desk staff. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim because it is not covered, you could be responsible for that amount.

If your insurance company is out-of-network, you have the right to receive a Good Faith Estimate (GFE) for the expected cost of your visits here at our center. If you receive a bill from us for a date of service that is more than $400 than the GFE listed below, you can dispute this bill at https://www.cms.gov/nosurprises.

Our normal and customary fees* are as follows:

Exam range: $85-$195

Chiropractic spinal adjustments $60-$70

X-rays if needed range from $60 to $70

*Fees subject to change

I have read the above policy regarding my financial responsibility to the Hoogeveen Chiropractic Wellness Center, for providing services to the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Hoogeveen Chiropractic.

Patient Signature: _____ Date: _____

Guarantor/Guardian Signature: _____Date:_____

The person responsible for payments on the above patient's account is:

_____ self

_____ other Name: _____ Relationship to patient: _____

Address: _____

Phone Number: _____ (in case we have billing questions)

Insurance Policy Holder Information (If you are ***not*** the subscriber (policy holder), please fill in the info below)

Policy Holder's Name: _____ Date of Birth: _____
Address: _____
_____
_____