PEDIATRIC NEW PATIENT INFORMATION

Date: _____

PATIENT INFORMATION

Child's Name: _____ Child's Nickname: _____

Reason for Visit: _____

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

Child's Home Phone #: _____

Child's Home Address: _____

Who may we thank for referring you? _____

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: _____

Predominent language used at home: _____

PAYMENT INFORMATION

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name: _____ Birth date: _____ SS #: _____

Insurance Company Name: _____ Phone No: _____

Insurance Company Address to send claims: _____

Employer: _____ Group No: _____ Insured's ID #: _____

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 named _____ as the examining / treating doctor deems necessary.

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

Parent's Name: _____ Signature _____

Date: _____ Witnessed by: _____

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Preston Peacock DC DABCO
408 SW HWY 80
Pooler GA, 31322
Phone 912-748-0350
Fax 912-450-0350
Email: info@poolerbackcare.com

PEDIATRIC HISTORY FORM

Purpose for contacting us? _____

Other Doctors seen for this condition: ☐ No ☐ Yes If yes, Doctors' names and Prior Treatments:
_____

Other Health Problem? _____

Check any of the following conditions your child has suffered from during the past six months:

☐Ear Infections ☐Scoliosis ☐Seizures ☐Chronic Colds
☐Headaches ☐Asthma/Allergies ☐Digestive Problems ☐ADHD ☐Fevers
☐Colic ☐Bed Wetting ☐Car Accident ☐Other

Family History: _____

Previous Chiropractic Care: ☐No ☐Yes Chiropractic Name: _____

Date of last visit: _____/____/____ Reason: _____

Name of Pediatrician: _____

Date of last visit: ____/____/____ Reason: _____

Are you satisfied with the care your child has received there? ☐No ☐Yes

Number of doses of **Antibiotics** your child has taken:
During the past six months: _____ Total during his/her lifetime:_____

Number of doses of **Other Prescription Medications** your child has taken:
During the past six months:_____ Total during his/her lifetime:_____
List: _____

Vaccination History: _____

Food/Juice Allergies or Intolerance: _____

Is/has your child been involved in any high impact or contact type sports? ☐No ☐Yes List:
_____

Has your child ever been involved in a car accident? ☐No ☐Yes List: _____

Has your child been seen on an emergency basis? ☐No ☐Yes List: _____

Other traumas not described above? _____

Prior Surgery? ☐No ☐Yes List: _____

Childhood Diseases: ☐ Chicken Pox ☐Mumps ☐Rubella ☐Measles ☐Whooping Cough

Advanced Chiropractic Center
Financial Policy

The following is a statement of our financial policy. We require you to sign and read this document prior to treatment by this facility.

Patients without Insurance:
We request that 100% of the first visit be paid at the time of service. We do offer a time of service discount for follow-up visits. We are happy to accept your cash/check, MasterCard, Visa or Discover Credit Card. **Initial_____**

Group or Individual Insurance:
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are **not a guarantee of payment.** As a courtesy to you, our office will file your claim with your insurance carrier. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, co pays or deductibles. It is the patient's responsibility to understand their insurance coverage.
Initial _____

Patient Responsibility
When you receive a statement from our office you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, please contact our office. Do not ignore the bill as it may result in turning the balance over to an outside collection agency.

I understand that I am financially responsible to Advanced Chiropractic Center for any balance not covered by the insurance carrier. **Initial _____**

Assignment of Benefits
I authorize this office to release any medical information relating to my treatment to any insurance companies, which may be responsible for paying benefits to me. I herby assign and authorize my insurance benefits to be paid directly to Advanced Chiropractic Center.

_____
Patient name (please print)

_____
Patient or Responsible Party's Signature Date

Preston Peacock DC DABCO

408 SW HWY 80
Pooler GA, 31322

Phone 912-748-0350
Fax 912-450-0350
Email: AdvancedChiro@hargray.com

Consent to Treat Minor

Patient Name: _____

I hereby request and authorize **Dr. Preston Peacock** to perform diagnostic tests and physical examination to_____.
(name of minor)

As of the date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date: _____ _____
Signature

_____ _____
Witness Printed Name

_____
Relationship to Patient