PARAGON WELLNESS CENTER

RECLAIM YOUR HEALTH. REVIVE YOUR LIFE.

Confidential Pediatric History Form

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To better serve you, please complete the following information. We look forward to working with you! Thank You!

Date: ________________________________Referred By: ____

Child's Name:____ Phone Number: ________________________

Do you have other immediate household family members who are patients here? Y N

If yes, please list them ____

Address:____________________________________ City:__________________ State:_____ Zip:___________

Sex:M F Weight:_________ Height:________ Birth Date:_______________

Name of Parents/Guardians:___________________________________ Phone Number:______________________

Purpose for Contacting Us?____

Other Doctors seen for this condition:Y N If yes, please list doctor's name and prior treatments: ___________

____

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

- ○ Ear infections
- ○ Asthma/Allergies
- ○ Colic
- ○ Scoliosis
- ○ Digestive problems
- ○ Bed Wetting
- ○ Seizures
- ○ ADHD
- ○ Auto Accident
- ○ Chronic Colds
- ○ Recurring Fevers
- ○ Temper Tantrums
- ○ Headaches
- ○ Growing/Back pains
- ○ Other: ________________ ____________________

Family History:____

Previous Chiropractor:_________________________________ Date of Last Visit:_________________ Reason:___________________

Were you satisfied? Y N Why? ____

Previous / Current Pediatrician:________________________________ Date of Last Visit:_____________ Reason:__________________

Number of doses of antibiotics your child has taken:

a) During the past six months:____

b) Total during his/her life:____

Dane Ericson DC
1332 W Arch Haven Ave Ste C, Bloomington, IN 47403
PH: 812.333.7447 | paragondrs.com

Number of doses of other prescription medications your child has taken:

c) During the past six months:____

d) Total during his/her life:____

Vaccination History: ____

Feeding History

Breast Fed:Y N If yes, how long?_________________ Formula:Y N If yes, how long:________________________

Introduced to solids at _____ months. Cow's milk at _____ months. Food/juice allergies or tolerances:Y N If Yes, Please List:

If Yes, please list:____________________________ Other allergies or tolerances: Y N If Yes, please list:____________________

Number of Hours Sleeping per Night: ___________ Quality of Sleep: Good Fair Poor

Prenatal History:

Name of obstetrician/midwife: ________________________________ Pediatrician / Family MD:

__________________________________ Birth intervention: Forceps________ Vacuum Extraction: _______ Caesarian Section: _______

Emergency or Planned?: ________________ Ultrasounds during pregnancy? Y N If yes, how many:_______________________

Medications during pregnancy/delivery?Y N If Yes, please list them:____

Cigarette/alcohol use during pregnancy?Y N How much and how often? ____

Childhood Diseases:

Chicken Pox: Y N Age:_____ Rubeola: Y N Age:_____ Whooping Cough: Y N Age:_____

Rubella: Y N Age:____ Other: ________________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? Y N – If yes, please explain___________________

____

____

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). Y N If Yes, Please list: ____

____

Has your child ever been involved in a car accident? Y N If yes, please explain:_____________________________________

____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE BOTH YOU AND YOUR CHILD TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

I hereby authorize Dane Ericson, DC - Affiliate of The Wellness Way to administer care to my son/daughter, as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. Please send completed form to **info@paragondrs.com**

Signed: ____ Relationship to Patient: ________________________ Date: _________________________

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial.

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in the practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure and disease or entity.

Initials: ______

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials: ______

I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) ____________

Initials: ______

I grant permission to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials: ______

I acknowledge that any insurance I may have is an agreement between the center and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials: ______

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

Initials ______

I grant permission for Paragon Wellness Center to charge my credit or debit card saved on file for services rendered in the event that verbal confirmation is not given or payment cannot be collected at the time of service.

Initials: ______

I acknowledge that any exam reservation deposit of $25 will be forfeited if I fail to give more than 24-hour notice to cancel my appointment, or arrive later than my scheduled arrival time and should need to be rescheduled as a result.

Initials: ______

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to a Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. Chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician of Paragon Wellness Center. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

- **The nature of the chiropractic adjustment.**
  I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- **The material risks inherent in chiropractic adjustment.**
  As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, 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 and during examination and X-ray. 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."

- **The availability and nature of other treatment options.**
  Other treatment options for your condition include:

  - Self-administered, over-the-counter analgesics and rest
  - Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
  - Hospitalization with traction
  - Surgery

I understand that if I am accepted as a patient by a physician at Paragon Wellness Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Name: ____

Patient Signature: ____ Date: __________

If patient is a minor or under a guardianship order as defined by State law:

Signature of Parent/Guardian (circle one) __________________________________ Date: __________

Witness: ____ Date: __________

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name________________________________
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By____________________________________ Date_______________
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____________________________________ Date_______________
Signature of Parent/Guardian (circle one)

Please list below anyone you would like to have access to your protected health information (PHI).

	Name	Relation	Phone
1.			
2.			
3.			
4.			
5.			

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Re: Assignment of Insurance Benefits/Authorization for Payment

Patient: ____

Employer: ____

Claim/Group#: ____

Insurance ID# and Date of Birth: ____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Dr. Lloyd Dane Ericson, DC
Paragon Wellness Center
1332 W. Arch Haven Ave. Ste. C
Bloomington, IN 47403

Tel: (812) 333-7447
Fax: (812) 333-7442
Email: https://paragondrs.com

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

____ c/o Dr. Lloyd Dane Ericson

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Insured's Signature: ____ Date: __________

If Insured is a minor or under a guardianship order as defined by State law:

Signature of Parent/Guardian (circle one) ___________________________________ Date: __________

Witness: ____ Date: __________