

Name: _____ DOB: _____ Date: _____

Nutrition: (please note the age/ length of time for each)

Breastmilk _____
 Bottle (pumped breast milk) _____
 Formula _____
 Solid Foods _____
 Does your child use any nutritional supplements? _____

Medical Interventions:

Please list any prescription medications your child has taken in the last year:

Please list any over- the- counter medications has your child taken in the last year:

How many prescriptions of antibiotics has your child taken in the last year? _____

How many antibiotics in his/her lifetime? _____

Vaccination History (please check those that apply)

- I have opted to not have my child vaccinated
- My child has been partially vaccinated

Vaccines given: _____

Vaccines refused: _____

- My child has been fully vaccinated
- My child has be given a flu shot

Years given: _____

Has your child ever been hospitalized? _____

Has your child ever undergone a surgical procedure? _____

Name of pediatrician/ family MD: _____

Review of Systems: Please indicate if you child has had any of the following symptoms or diagnoses in the past year or in their lifetime and any treatment they received for it.

Past year: Lifetime:

Treatment:

- | | | | |
|--------------------------|--------------------------|----------------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Infections _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic colds/cough _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent Fevers _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Colic _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach/digestive problems _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bed Wetting _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | ADHD _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning Disorder _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Temper Tantrums _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleeping Problems _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (please explain): _____ | |



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Please circle any health-related topics you would like to learn more about for your child:

Nutrition Physical Activity Sleep Stress
Toxins Medications Vaccinations Immune system

Other (please list): _____

OFFICE FINANCIAL POLICY

For your convenience, we accept cash, check, Visa and MasterCard. We also offer Care Credit plans, a private financing company that allows you to make interest free payments and/or defer or spread payments over an extended period of time.

1. **If you do not have insurance:** All payments are expected at the time of service or by a prepaid wellness plan. Any other payment arrangements must be made with the billing department prior to the services being rendered. Date of service discounts will only apply when payment is received that day; payments received beyond that day will be subject to the full standard rate. Patients who do not have insurance will be denied care if payment has not been received for two or more past visits.

2. **If you have insurance:** All co-payments are expected at the time of service. Patients who have a co-payment will be denied care if co-payment has not been received for two or more past visits.

All deductible plans will first be submitted to your insurance company and, following receipt of benefits, a statement of your responsibility will be sent to you. In order to avoid accumulating an unmanageable balance, individual accounts are not allowed to exceed \$200 and family accounts cannot surpass \$300. Chiropractic care will not be rendered if balances exceed these amounts. We welcome periodic payments while we wait to hear back from your insurance company in order to keep your account balance manageable.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

Who is responsible for this account? _____ Relationship to Patient _____
Do you plan to have insurance claims submitted for your care at our office? Y / N
Please note: Your signature on this intake form denotes that you understand you are responsible for all charges whether or not paid by insurance. You authorize the doctor(s) to release all information necessary to secure the payment of benefits. You authorize the use of your signature here on all insurance submissions. Please answer the following questions:
What company services your primary insurance? _____
Who is the policyholder for this plan?
Name: _____ DOB: _____ SSN: _____
Do you have a secondary insurance? Company: _____
Who is the policyholder for this plan?
Name: _____ DOB: _____ SSN: _____
Do you have any other insurance benefits that you would like to use? _____
If you utilize MEDICARE benefits, do have a Medicare Advantage Plan? Company name: _____
If you utilize MEDICARE benefits, do you have a supplemental plan? Company name: _____

Patient's signature: _____ Date: _____

Parent/ Guardian signature: _____

Cornerstone Chiropractic Staff: _____