Renaissance Chiropractic Center

4902 Tacoma Mall Blvd., Tacoma, WA 98409 253-473-0300

Patient Name (F)_____(MI)_____ (L)_____ Date _____

SS # _____ Sex M or F Birthdate _____Age _____

Parent/Guardian's Name _____Relationship _____

Birthdate _____ Parent's SS # _____

Address _____ City _____ State _____ Zip _____

Home ( ) _____ Cell ( ) _____ Work ( ) _____

Insurance Information:

Ins Co:_____ Subscriber:_____ ID/Group #:_____

HISTORY

Type of Birth: [Vaginal] or [C-section] Place of Birth: [Home] or [Hospital]
Use of: [Forceps] or [Vacuum Extraction] Breast Fed: Y or N
Immunizations: Y or N

Accidents/Falls: (i.e. auto accident, sports injury, falls: off bike, out of tree, off bed or changing table)
1._____ When: _____

2._____ When: _____

3._____ When: _____

Currently taking medications: Y or N List:_____
Surgeries Y or N For:_____

Has your child had any of the following health conditions since birth: (PLEASE CIRCLE)

	EVER	PRESENTLY	MEDICATIONS
1. Ear infections (Did they take antibiotics Y or N)	Y or N	Y or N	Y or N
2. Allergies	Y or N	Y or N	Y or N
3. Colic	Y or N	Y or N	Y or N
4. Frequent colds	Y or N	Y or N	Y or N
5. Bedwetting	Y or N	Y or N	Y or N
6. Tonsillitis	Y or N	Y or N	Y or N
7. Sinus infections/constant runny nose	Y or N	Y or N	Y or N
8. Attention Deficit Disorder (ADD)	Y or N	Y or N	Y or N
9. Developmental Disorder	Y or N	Y or N	Y or N
10. Digestive problems	Y or N	Y or N	Y or N
11. Headaches	Y or N	Y or N	Y or N
12. Back or Neck pain	Y or N	Y or N	Y or N
13. Growing pains	Y or N	Y or N	Y or N
14. Other			

_____

_____

Please read through each paragraph, initial, sign and date.

____ Acknowledgement of Receipt of Notice of Privacy Practices:

RENAISSANCE CHIROPRACTIC CENTER USES PERSONAL INFORMATION ONLY AS RELATED TO PROVIDING CARE AND BILLING PURPOSES IN ACCORDANCE WITH STATE AND FEDERAL PRIVACY GUIDELINES. WE DO NOT SHARE YOUR INFORMATION BEYOND WHAT IS REQUIRED FOR THESE PURPOSES. I acknowledge that I may request a copy of the Notice of Privacy Practices or I have declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

____ Financial Responsibility:

I hereby state that the information on this form is true and correct. I authorize Renaissance Chiropractic Center to examine, take x-rays (if necessary), treat me, and do whatever they deem necessary in accordance with the state statutes, for the care and management of my condition**.** I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. I also understand that Renaissance Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to Renaissance Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered me will be immediately due and payable. Your account will be assessed a $35.00 cancellation fee if our office is not contacted 24 hours prior to your scheduled appointment. **Insurance benifts are based on a "Good faith" quote from your insurance company. However, this is not a guarantee of payment.**

___ Terms of Acceptance:

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. I, _____, have read and fully understand the above statements.

(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature _____ Date _____

I, parent/guardian, give permission for minor's care_____

Revised 9/2010