# Welcome to Reinarts Family Chiropractic

We want to thank you for choosing Reinarts Family Chiropractic and for giving us the chance to help you. With your cooperation, I am sure that you will obtain the results you seek. We will do whatever it takes to help you get well as soon as possible.

The purpose of our office is to serve you, and we will be happy to answer any questions concerning your health care. We pride ourselves on serving happy, healthy and enthusiastic patients. Also, please let us know if there is ever a concern or problem you need to discuss (e.g. concern about your care, finances, etc.). Your comments help us to identify areas of concern and thus, help our office improve our service to our clients.

As you begin to improve, share your joy and health with your friends and loved ones; we always appreciate referrals! Once again, thank you for choosing our office, and we look forward to working with you to help you regain optimum health.

Sincerely,

Dr. Jason Reinarts

# Our Mission

To create a healing environment in which people take individual responsibility and learn to maximize their optimum health potential. We do this by listening and becoming aware of the person's individual needs so that we may utilize tools and resources that will best serve their body, mind, and spirit. Our fundamental approach includes clearing the nerve system, increasing structural integrity, providing nutritional support, decreasing emotional tension and inspiring people to make better choices in sickness and in health.

# New Pediatric Patient Intake

**It's all about the uniqueness of your child**

**PATIENT INFORMATION**

**Patient Name:** ____________________________________________________________ Date:________________________

**Preferred Name**:____________________________________________________________

DOB: _____________________ Age: ______________________ Sex: ____Male ____ Female

Address: ___________________________________________________ City: ________________________ State: ________ Zip: ___________

Home #: (______)______________________ Office #:(______)_____________________ Cell #:(______)______________________
Where do you prefer to receive calls? ___Home ___Office ___Cell ___No preference

Whom may we thank for referring you to us? _______________________________________________________________________________

**RESPONSIBLE PARTY**

Name of Person Responsible for Account ___________________________________________________________________________________

Relationship to Patient ____________________________________________________ Phone #: ____________________________________

Address: ___________________________________________________ City: ________________________ State: _________ Zip: __________

e-mail____________________________________________________________________________________________________

Name of Employer: _____________________________________________________ Work #: ________________________________________

**CERTIFICATION AND ASSIGNMENT**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _______________________________________________and assign directly
Name of Insurance Carrier

To Dr. Jason T. Reinarts all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on al insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Carrier and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_________________________________________________________________________________ ______________________________
Signature of Parent, Guardian or Personal Representative Date

_________________________________________________________________________________ ______________________________
Print Name of Parent, Guardian or Personal Representative Relationship to patient

# New Pediatric Patient Intake

**Present Health Challenge(s):**

For what health challenge(s) is your child here for?

______________________________________________________________________

What do you feel is the cause of your child's problem?

______________________________________________________________________

When did you first notice this sign of body dysfunction?

______________________________________________________________________

Is this dysfunction getting progressively worse? ___Yes ___No
If yes, why do you think so?

______________________________________________________________________

Please mark and X for any of the following that apply.

| | | | |
|---|---|---|---|
| ____ ADD/ADHD | ____Frequent colds/ congestion | ____Upper respiratory Infections | ____Asthma |
| ____Ear infections | ____Infected/sore Throat | ____Tonsillitis | ____Laryngitis |
| ____Colic | ____Reflux/spitting up | ____U-tract infections | ____Poor appetite |
| ____Poor digestion/ (constipation/diarrhea) | ____Thrush mouth/ Chronic diaper rash | ____Eczema/psoriasis/ Other skin rashes | ____ADD/ADHD |
| ____Irregular sleep Patterns | ____Night terrors | ______Bed wetting | ____Headache |
| ____Anxiety | ____Mood swings | ____Bruising | Other__________________ |

# New Pediatric Patient Intake

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

| | **Father** Age____ | **Mother** Age____ | **Spouse** Age____ | **Brother**(s) Age____ Age____ | | **Sister**(s) Age____ Age____ | | **Children** Age____ Age____ Age____ | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **First Name** | | | | | | | | | | |
| **Condition** | | | | | | | | | | |
| Allergies | | | | | | | | | | |
| Anxiety | | | | | | | | | | |
| Arthritis | | | | | | | | | | |
| Auto Accidents | | | | | | | | | | |
| Back Pain | | | | | | | | | | |
| Cancer | | | | | | | | | | |
| Constipation | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Disc Problems | | | | | | | | | | |
| Epilepsy | | | | | | | | | | |
| Frequent Colds/Flus | | | | | | | | | | |
| Gassy/Bloating | | | | | | | | | | |
| Headache | | | | | | | | | | |
| Heartburn | | | | | | | | | | |
| Heart Trouble | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | |
| Low Energy | | | | | | | | | | |
| Migraine | | | | | | | | | | |
| Neck Pain | | | | | | | | | | |
| Nervousness | | | | | | | | | | |
| Pinched Nerve | | | | | | | | | | |
| Scoliosis | | | | | | | | | | |
| Sinus Trouble | | | | | | | | | | |
| Sleeping Problems | | | | | | | | | | |
| Other: | | | | | | | | | | |
| Other: | | | | | | | | | | |

# New Pediatric Patient Intake

Is there anything else you feel we should know about your child?_______________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

## Certifications and Assignment

This office conforms to the current HIPPAA Guidelines. You may request a copy of our HIPPAA policies at the front desk. Please initial to indicate you have been made aware of its availability________________________
I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient/Guardian Signature______________________________________________________________

Date__________________________________________________________________________________

Print Name/Patient__________________________________________________________________